Wiede Vissers

The Measurement of Remoralization

An Extension of Contemporary Psychotherapy Outcome Research

The Measurement of Remoralization: An Extension of Contemporary Psychotherapy Outcome Research

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An Extension of Contemporary Psychotherapy Outcome Research

Een wetenschappelijke proeve op het gebied van de Sociale Wetenschappen

Proefschrift

ter verkrijging van de graad van doctor
aan de Radboud Universiteit Nijmegen
op gezag van de rector magnificus prof. mr. S. C. J. J. Kortmann,
volgens besluit van het college van decanen
in het openbaar te verdedigen op woensdag 13 oktober 2010
om 15.30 uur precies
door

Wiede Vissers

geboren op 19 augustus 1979
te Eindhoven

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Omslagontwerp: PostelOntwerpen
Drukkerij: GVO drukkers & vormgevers B.V. | Ponsen & Looijen
ISBN: 978-90-9025655-9

The studies described in this dissertation were co-funded by The Netherlands Organization for Health Research and Development (ZonMw: 100002025).

Table of Contents

Chapter 1. General Introduction

Current psychotherapy outcome research: Focus on symptom reduction

Goldfried and Wolfe (1996) have described three generations in the history of psychotherapy[1] outcome research. The *first generation* of research was conducted in the 1950s and 1960s, and it was aimed at the investigation of whether psychotherapy can elicit personality change or not. Little specification or differentiation of the different forms of psychotherapy and research methods occurred. The *second generation* of psychotherapy outcome research was conducted in the 1960s and 1970s. The research themes were much more specific than before, and the question was now if a specific treatment could reduce the symptoms of a specific disorder. Control conditions and randomization procedures were introduced into the research designs. The *current generation* of psychotherapy outcome research, as described by Goldfried and Wolfe, originated in the 1980s and is the most widely used paradigm in psychotherapy outcome research today. The research methodology is based upon the medical model and generally aimed at investigation of the effects of specific, manual-based treatments compared to other well-defined treatments and/or control groups. Patients with clearly defined DSM-IV diagnoses are typically assigned at random to an experimental treatment condition, alternative treatment conditions or control conditions. Treatments are conducted under optimal circumstances in order to test the best possible treatment effect. The therapists for instance, are carefully trained. This type of research is referred to as *efficacy research.* Over the years psychotherapy outcome research has thus ruled out as many sources of variance (i.e., patient, therapist, and treatment variation) as possible which were not part of the main research interest. The ultimate result, also stimulated by Division 12 of the American Psychological Association (APA), is that one can now speak of "empirically supported treatments" (ESTs). Examples of such are psychological treatments available today for anxiety disorders, mood disorders, somatoform disorders, substance abuse, and eating disorders (Carr, 2009; Chambless & Ollendick, 2001; Keijsers, van Minnen & Hoogduin, 2010; Roth & Fonagy, 2006).

For the current generation of psychotherapy outcome research, the main question is whether a specific treatment effectively reduces symptoms of psychopathology. For patients with social phobia, for example, the question is to what extent a specific treatment reduces disorder specific symptoms such as fear of social and/or performance situations, the experienced anxiety when patients are exposed to such situations, and the level of avoidance of such situations, compared to another treatment or control group. In 1998, the renowned *Journal of Consulting and Clinical Psychology* devoted a special issue to ESTs. Both advocates and critics of the EST presented their views on — among other issues — the use of randomized controlled clinical trials as the golden standard for efficacy research, the use of highly trained therapists, the advantages and disadvantages of strict patient selection, the use of treatment manuals, the transferability of the out-

[1] By psychotherapy, we understand all common varieties of psychological treatments

comes of controlled clinical trials to clinical practice, and the differences between efficacy and effectiveness research (see, among others, Beutler, 1998; Borkovec & Castonguay, 1998; Chambless & Hollon, 1998; Goldfried & Wolfe, 1998). Remarkably, almost no discussion of the definition of treatment outcome measure occurred. Sometimes explicitly but mostly implicitly, the authors seemed satisfied with the assessment of the level of symptom reduction as the only outcome measure to establish the effects of ESTs. Only Chambless and Hollon mentioned the desirability to go beyond symptom assessment to examine the effects of treatment on more general measures of functioning, but they observed that only a very few studies included such measures. This one-sided view of symptom reduction as the only important outcome measure has become so pervasive in the present generation of outcome research that a treatment is now referred to as "effective" without further clarification that "effective" means with respect to symptom reduction.

Underlying this symptom-focused approach, a specific and rather restricted notion of health and disease can be discerned, namely that the reduction of the symptoms of a mental disorder is sufficient to increase mental health. It is suggested, thus, that psychopathology and mental health are at the opposite ends of a single mental health continuum and that good mental health is the absence of symptoms of psychopathology. However, various authors in the area of mental health care have taken issue with the focus of psychotherapy outcome measurement on solely symptom reduction (Hill & Lambert, 2004; Jacobson, Roberts, Berns, & McGlinchey, 1999, Mirin & Namerow, 1991; Perkins, 2001). Effective symptom reduction does not, for example, necessarily imply positive changes in the individual's subjective sense of well-being, the quality of his or her social relationships (Mirin & Namerow), or an increased sense of control or greater engagement in activities (Perkins). Conversely, for a chronic mental illness such as schizophrenia, it is known that an increased sense of control and reduction of hopelessness can be realized without a change of negative symptoms (Shrivastava, Johnston, Shah, & Bureau, 2010; Strauss, 1994). Successful treatment typically yields a variety of positive effects and not just symptom reduction (Goldfried & Wolfe, 1996; Perkins; Wampold, 2001).

The definition of effective treatment in terms of only symptom reduction also produces an overly narrow view of treatment from the perspective of patients. Most patients mention symptom reduction as a reason for entering into treatment, but Grosse Holtforth and Grawe (2002) found only a small minority of patients to mention symptom reduction as the only or most important goal. Increased interpersonal functioning, well-being, and personal development were also frequently mentioned as goals for seeking treatment. Connolly and Strupp (1996), studying the literature on patients' perceptions of change, found that changes in self-concept were reported in addition to symptom relief. More recently, Levitt, Butler, and Hill (2006) found symptom reduction

per se to be rarely mentioned by patients as an important outcome of treatment; relating better with others and feeling better about themselves were mentioned instead.

The idea that the effects of therapy consist of more than symptom reduction is far from new. Already in 1948, the World Health Organization (WHO, p.1) stated that "[health is] a state of complete physical, mental and social well-being and not merely the absence of disease." However, the number of studies on the underlying structure of mental health is limited. It was only in 2005, that Keyes showed measures of mental health and mental illness to constitute correlated but separate unipolar dimensions. In other words, a one-sided focus on symptom reduction, as is the case in most efficacy studies of psychological treatment, runs the risk of leaving an important part of mental health out of the discussion.

The reason for the current emphasis on symptom reduction may lie in the world-wide use of an a-theoretical classification system for psychopathology, namely the Diagnostic and Statistical Manual of Mental Disorders (DSM) -III, -IV, and -IV-R (American Psychiatric Association, 1980, 1987, 1994). The uniform terminology offered by the DSM for the description of mental disorders provides a standardized system of symptom measurement and allows researchers to submit grant proposals that meet standard scientific criteria (Mayes & Horwitz, 2005). From the original DSM-III on, the medical model was adopted in the classification of psychopathology, and therewith the focus on symptoms.

An additional practical reason for the current emphasis on symptom reduction may be that symptom reduction is also the most unequivocal means to determine the effects of treatment because symptom reduction is measured in a fairly similar manner by all kind of researchers and for all kind of treatments. Therefore, the outcomes of studies can be compared and incorporated, for example into meta-analyses (see, for instance, Gould, Otto, & Pollack, 1995; Westen & Morrison, 2001). The one-sided focus on symptom reduction in psychotherapy outcome research might also, as already mentioned, be due to the equation made by many researchers of mental health with the absence of psychopathology.

In previous years, the field of psychotherapy made tremendous improvements in classifying and treating a large variety of mental disorders. Nevertheless, there are unwanted consequences of the current one-sided focus on symptom reduction as the only measure of psychotherapy treatment outcome. To start with, this one-sided focus can actually hamper the implementation of evidence-based knowledge into clinical practice. That is, many clinicians do not sufficiently recognize elements of clinical practice or characteristics of their patients in today's research paradigm. Clinicians perceive psychotherapy outcome research to be biased and thus of limited use for actual clinical practice (Hutschemaekers, 2003; Mirin & Namarow, 1991; Takens, 2004). According to the American Psychological Association (Presidential Task Force on Evidence Based Practice, 2006), for example, the inclusion of the subjectively lived

experiences of patients in psychotherapy outcome research is important because it can strengthen the relation between research and practice.

A second unwanted consequence of the focus on solely symptom reduction is a neglect of the other treatment goals mentioned by patients. Patients mention change other than symptom reduction as the goal of their treatment but these goals of treatment are ignored in current research paradigms.

A third unwanted consequence is that the current one-sided focus on symptom reduction possibly also leads to a biased selection of treatments. Little is known about the effects on important other outcomes. There is a possibility that certain treatments are incorrectly perceived as less effective when the evaluation is in terms of symptom reduction only. Broadening outcome research to include measures other than just symptom reduction that are valid and reliable as outcome measures, may produce a different picture of which treatments can be judged to be effective. In any case, the broadening of psychotherapy outcome research will certainly deepen the discussion of which treatments are effective.

A fourth unwanted consequence of the evaluation of only symptom reduction is that negative side-effects of treatment are not considered. Treatment can make a patient dependent upon treatment or foster feelings of powerlessness on the part of a patient while nevertheless effectively reducing the symptoms of a specific disorder. With the one-sided focus on symptom reduction an overly optimistic picture of the effects of treatment can thus be painted at times.

Fifth and finally, there are patient groups such as those with schizophrenia or somatization disorder for whom symptom reduction is virtually unattainable. In the current research tradition, these patients are considered minimally treatable. They can, however, show marked progress on other treatment outcomes and thus an increased sense of control and reduced hopelessness, for example, (Shrivastava, Johnston, Shah, & Bureau, 2010; Strauss, 1994). In other words, these patient groups may actually be judged to be *treatable* when a psychotherapy outcome measure other than symptom reduction is employed.

In search of supplementary outcome measures

In light of the above discussion of the shortcomings of the current generation of psychotherapy outcome research, a broader perspective on the measurement of psychotherapy outcome is clearly desirable. Let us examine what measure or measures can be employed in order to attain a more complete picture of psychotherapy outcome.

This measure should describe positive change, which is not captured by the measurement of specific features of syndromes or specific symptoms. In the literature, there are various positive changes described. In the definition of health by the WHO,

both mental and social well-being are mentioned (WHO, 1948). Patients mention 'getting a grasp on their lives', 'having a more positive perspective on the future', and 'learning to cope with difficulties' (Boevink, Wolf, Nieuwenhuizen, & Schene, 1995). Researchers mention such concepts as subjective well-being, (Mirin & Namerow, 1991), a sense of control, and engagement in activities (Perkins, 2001). The term *quality of life* is also mentioned when other treatment changes are discussed (Gladis, Gosch, Dishuk, & Crits-Christoph, 1999). The list can be broadened to include dozens of other concepts that refer to all kinds of changes that are realized apart from symptom reduction by effective treatments. All these concepts seem to focus on positive changes such as self-worth, well-being, and personal strength.

Given the multitude of positive changes, it is far from evident which measure should be added to outcome research to broaden it. To keep out of the rivalries between different traditions and schools of thought, but also to enlarge the chances of the concept being relevant for various mental health patients, the concept should not be restricted to a particular psychotherapeutic tradition or specific patient populations. The concept should also gauge conditions that are known to change as a result of successful psychotherapy.

Several concepts have been introduced over the years to describe positive effects that go beyond symptom reduction for psychotherapeutic treatment. In the field of social psychiatry, the concept of *empowerment* (Rogers, Chamberlin, Ellison, & Crean, 1997) has been put forth. In certain psychotherapeutic traditions, the concepts of *ego strength* (Kernberg et al., 1972) and *self-actualization* (Maslow, 1970) are quite well-known. However, the aforementioned concepts do not have a concise meaning outside the specific traditions in which they are embedded. The popular term *quality of life* is not limited to a specific tradition but lacks a clearly agreed upon definition (Gladis et al., 1999). The attempt of Katschnig (1997) to define quality of life is illustrative: "a loosely related body of work on psychological well-being, social and emotional functioning, health status, functional performance, life satisfaction, social support, and standard of living, whereby normative, objective, and subjective indicators of physical, and emotional functioning are all used" (p.6). The existence of hundreds of different instruments to measure quality of life further confirms the lack of a clearly agreed upon definition (Gladis et al.).

When evaluating the classical theories about change of mental health care patients, the demoralization theory of Jerome Frank (1974) stands out. The concept of *remoralization* or the restoration of morale is of significance for not only different treatment approaches; there is also a good consensual definition. The question of whether it is a useful measure in outcome research has yet to be addressed, however. In the remainder of this general introduction, the concept of demoralization and its reverse, namely the concept of remoralization, will therefore be examined in greater detail and particularly with respect to their value as measures of psychotherapy outcome.

Thereafter, the relation between the measurement of remoralization and the measurement of symptom reduction will be considered and the question of just how remoralization relates to symptom reduction in treatment outcome research in particular.

The value of remoralization as an outcome measure

In his book entitled *Persuasion and Healing* (1973), Frank states that people who enter into treatment for psychological problems typically suffer from not only a specific mental disorder (i.e., symptomatic burden) but also feel demoralized. According to Frank (1974), the painful experience of symptoms and the accompanying negative emotions over a longer period of time can lead to feelings of hopelessness and powerlessness, which are central to the state of demoralization. Demoralization thus results from the belief of not being able to solve current problems and is thus characterized by feelings of impotence, isolation, and despair. De Figueiredo and Frank (1982) have described demoralization as involving two dimensions: subjective incompetence and distress. Subjective incompetence is described as a feeling of inability to plan and initiate concerted action towards one or more goals, and the actions of demoralized individuals tend to lack direction as a result of this (de Figueiredo, 2007). Distress is described as the incapacity of a person to adapt to stressful events by de Figueiredo and Frank, and it is characterized by feelings of discouragement, anger, and sadness.

Subjective incompetence, by itself, and distress, by itself, can be seen as normal. Their overlap, however, can be very impairing and thus lead to a state of demoralization. To remoralize, subjective incompetence must therefore be resolved, on the one hand, and distress must be reduced, on the other hand (de Figueiredo, 2007). The first requires that the person again *belie*ve that he or she is competent. The latter requires coping with a particular stressor.

According to Howard, Lueger, Malin, and Martinovich (1993), remoralization is the enhancement of subjective well-being, and is realized early in treatment. When a treatment clarifies a patient's problems, inspires hope, and provides experiences of success and mastery, it is likely to remoralize (Frank, 1973). According to Frank (1974), moreover, "[treatment should] heighten the patient's sense of mastery over the inner and outer forces assailing him by labeling them and fitting them into a conceptual scheme, as well as by supplying success experiences" (p. 272). Slavney (1999) has similarly pointed out that a therapist should try to normalize a patient's distress in order to remoralize the patient. That is, the patient's mood and concerns should be attended to and the patient's distress validated (i.e., acknowledged as normal for an individual responding under abnormally difficult) in order to promote remoralization.

Although a state of demoralization may *look* like a major depressive disorder, researchers show that it is different and can be distinguished from depression (Clarke & Kissane, 2002; de Figueiredo, 1993; Mangelli et al., 2005). Depression is characterized

by anhedonia — diminished interest or pleasure in all, or almost all, activities — whereas demoralization is defined by de lack of looking forward to the future with pleasant anticipation. The individual who is demoralized can actually enjoy the present (de Figueiredo), but suffers from subjective incompetence due to uncertainty about what course of action to take; the depressed individual suffers from apathy even when action is called for and the type of action necessary is clear. In a study of psychiatric morbidity among medically ill patients, Clarke, Mackinnon, Smith, McKenzie, and Herrman (2002) found separate latent symptom structures of anhedonia and demoralization. Additionally, they found that suicidal ideation also associated differently with demoralization and depression. The states of depression and demoralization are known to frequently overlap but not be necessarily connected. While Mangelli et al. found some of their sample of medically ill patients to be both depressed *and* demoralized, 44% of the depressed patients were not demoralized and 70% of the demoralized patients were not depressed.

Remoralization can thus be viewed as a valuable candidate to supplement symptom reduction as a measure of psychotherapy outcome because it indeed appears to be an important outcome of psychotherapy, can be expected to change when treatment is effective, and it is not a feature of a specific syndrome or a specific symptom. In the following, how remoralization appears to relate to symptom reduction will therefore be considered further.

The conceptual relation of remoralization to symptom reduction

According to Frank (1973), people who enter into treatment suffer from not only symptomatic burden but also feel demoralized, which means that effective treatment must realize both remoralization and symptom reduction. Remoralization and symptom reduction are viewed as two distinguishable outcomes of treatment. At the same time, however, these two outcomes are expected to influence each other. As Frank (1974) stated, demoralization can aggravate symptoms and symptoms can aggravate demoralization. Similarly, de Figueiredo (2007) states that “An illness may set the stage for appearance of demoralization which, in turn, may worsen the prognosis of the illness.” (p131). From such a perspective, thus, remoralization and symptom reduction can be assumed to be interdependent but distinguishable.

Another renowned theory that provides insight into the theoretical distinction between remoralization and symptom reduction is the *phase model of psychotherapy outcome*. Howard et al. (1993) designed the phase model to describe the different stages of change that characterize the course of psychotherapeutic treatment and not to provide information on the distinction between remoralization and symptom reduction, but the phase model nevertheless provides insight into the relations between remoralization and symptom reduction. In the phase model, psychotherapy is assumed to progress in a stepwise manner with each phase depending upon a previous phase and each phase

assumed to represent a different domain of psychotherapeutic change. The first phase in the model draws upon the demoralization theory of Frank and is therefore referred to as the *remoralization phase*. During this phase, patients overcome their state of demoralization, regain hope that their problems can be resolved, and experience an increased sense of subjective well-being as a result. The second phase addresses the symptoms of the patient and is referred to as the *remediation phase*. Coping is facilitated and improved in order to bring about symptom relief. The third phase is the *rehabilitation phase*, which is "focused on the unlearning of troublesome, maladaptive, longstanding patterns and the establishment of new ways of dealing with various aspects of self and life" (Howard et al., p. 680).

It is apparent from the description of the first two phases of the phase model that Howard et al. (1993) considered remoralization and remediation to constitute different phases in the process of psychotherapeutic change, and they thus considered different psychotherapeutic outcomes. In other words, remoralization and symptom reduction are two distinguishable effects of treatment. Considering de Figueiredo (2007), Frank (1974), and Howard et al., it is clear that remoralization and symptom reduction can be distinguished at a conceptual level.

Remoralization, with respect to its theoretical content, is a valuable candidate to broaden the measurement of treatment outcome. However, to really be a valuable measure, remoralization must also have practical significance and it must be possible to operationalize the notion. The measurability of remoralization will thus be considered along with its empirical relation to symptom reduction in the following.

Remoralization at an operational level

The measurability of remoralization

In order to measure remoralization in mental health patients, a reliable and valid instrument must be available. Three instruments appear to have some potential for the measurement of remoralization. The first is the Psychiatric Epidemiological Research Interview-Demoralization (PERI-D) from Dohrenwend, Shrout, Egri, and Mendelsohn (1980). However, the PERI-D has several disadvantages when considered for use as an outcome measure. First, it is an interview and therefore its administration is rather time-consuming and complicates research logistics as opposed to a self-report instrument. Second, the PERI-D is a classification instrument (i.e., it produces a classification of the individual as demoralized or not), and is therefore not particularly well-suited to determine the level of demoralization following treatment. That is, the PERI-D may have a low level of sensitivity to change. In addition, the fact that the respondents are asked to estimate their demoralization for the entire past year also reduces the sensitivity of the PERI-D to change. Third, the PERI-D contains a number of items that

concern symptoms of anxiety, depression, and psychosomatic problems, which makes it less suited to measure an outcome of treatment not captured by symptom reduction. Fourth, eight highly intercorrelated subscales provide information on the state of demoralization but their intercorrelations make things difficult to interpret. The last disadvantage of the PERI-D as a measure of demoralization is that de Figueiredo and Frank (1982) explicitly stated that the PERI-D does not encompass a broad conceptualization of demoralization as it only contains items that assess distress and not subjective incompetence.

The second instrument is the Demoralization Scale (DS) from Kissane, Wein, Love, Lee, Kee, and Clarke (2004). The DS consists of 24 items and 5 highly correlated dimensions of demoralization: disheartenment, loss of meaning, non-specific dysphoria, helplessness, and sense of failure. Interpretation problems also thus occur because of the high correlations between the dimensions of demoralization. The high correlations raise the question of whether the DS is really a multidimensional scale. The DS aims to measure demoralization in somatic health care patients and it has only been validated using a relatively small ($N = 100$) and highly homogeneous sample of patients suffering from a chronic somatic illness (i.e., cancer) and no data has been collected on the test-retest reliability of the scale or its underlying factor structure. The suitability of the DS for use with mental health patients and its psychometric properties when used with such patients are thus unknown. Finally, the DS measures a negative state and therefore emphasizes what is wrong (i.e., problems). This may be demoralizing in and of itself, particularly when the instrument is administered repeatedly throughout the course of treatment.

The third instrument is the subjective well-being scale (SWS) from Howard et al. (1993). In addition to the original two-item form from Howard et al, a three-item form (Grissom, Lyons, & Lutz, 2002) and a four-item form have also been developed (Callahan, Swift, & Hynan, 2006). The SWS has been constructed to measure change in patients during the remoralization phase of treatment. The SWS is the only scale that is known in the literature to evaluate the positive process of remoralization. Therefore it has significance. At the same time there are several issues that might cause difficulties when this instrument is adopted to broaden current outcome research. The items on the original form were as follows: “At the present time, how well do you feel you are getting along emotionally and psychologically?” and “At the present time, how upset and distressed have you been feeling?” (Howard et al., p. 860). These items do not encompass Frank’s broader conceptualization of demoralization. The SWS is specifically directed to the patients’ distress and lacks items concerned with subjective incompetence. Furthermore, the use of a scale with such a small number of items is methodologically limited; the reliability and the content validity of the scale can easily drop below acceptable values. Finally, in most of the current outcome research,

treatments for specific diagnostic groups of patients are evaluated. The subjective well-being scale, in contrast, has only been used with heterogeneous patient samples.

Despite the aforementioned concerns, studies using the SWS have all shown remoralization to change significantly and reliably for most patients (Callahan et al., 2006; Hilsenroth, Ackerman, & Blagys, 2001; Howard et al. 1993; Joyce, Ogrodniczuk, Piper, & McCallum, 2002; Lutz, Lowry, Kopta, Einstein, & Howard, 2001; Martinovich, 1998). This is a promising result.

In sum, there is no instrument that can be judged sufficiently appropriate to measure changes in remoralization as a result of treatment among mental health care patients available today. This is a practical difficulty for the addition of measures of remoralization to outcome research.

Distinguishing remoralization from symptom reduction

In addition to the measurability of remoralization, whether or not it can be empirically distinguished from symptom reduction and whether or not the measurement of remoralization thus has added value for psychotherapy outcome research must be determined. While Frank (1974) asserted that the process of remoralization can be theoretically differentiated from the process of symptom reduction, he — himself — never investtigated this assertion empirically. Howard and colleagues (1993) similarly describe the changes in remoralization and symptom reduction as two distinguishable processes. And this has also been done in later studies (Barkham, Rees, Stiles, Shapiro, Hardy, & Reynolds, 1996; Callahan et al., 2006; Hilsenroth et al., 2001; Holloway, 2004; Howard et al., Joyce et al., 2002; Kopta, Howard, Lowry, & Beutler, 1994; Lutz et al., 2001; Martinovich, 1998). None of these studies, however, explicitly investigated the relation between remoralization and symptom reduction or provided specific information on the relation between remoralization and symptom reduction. Their findings can nevertheless shed some light on the differentiation of remoralization from symptom reduction and the possibly added value of measuring remoralization in addition to symptom reduction.

A total of five studies (Barkham et al., 1996; Hilsenroth et al., 2001; Howard et al., 1993; Kopta et al., 1994; Lutz et al., 2001) showed a larger percentage of their patients to improve more on remoralization than on symptom reduction. Whether or not symptom reduction (i.e., the remediation phase) actually constitutes a *later* phase of change than remoralization can, strictly speaking, not be deduced on the basis of this data, however. The ratio of patients who improved on remoralization to patients who improved on symptom reduction did not change over time. That is, the improvement ratio for remoralization relative to symptom reduction was *stable* across the course of treatment. Inspection of the figures depicting the percentages of patients improved for remoralization and the percentages of patients improved for symptom reduction over time (Barkham et al.; Howard et al.; Kopta et al.) also reveals virtually identical growth lines for the two measures. It is thus not clear that one measure actually changes *earlier*

than the other or one measure accelerates at a different point in time than the other. In the figures of Howard et al. and Kopta et al., moreover, the changes in remoralization are found to be largest during the first few treatment sessions, but this was also the case for symptom reduction. In other words, remoralization does not accelerate earlier than symptom reduction, which suggests that the changes in the two co-occur.

Whether or not remoralization and symptom reduction are clearly separate or overlap considerably remains to be seen, thus. Related to this issue, we do not know if the measurement of changes in remoralization provides information that is supplemental and useful for the proper evaluation of treatment outcomes when employed in addition to symptom reduction.

Aims and outline of the present dissertation

Many authors have taken issue with the one-sided focus of current psychotherapy outcome research on symptom reduction. Despite these concerns, a valuable construct to be added to symptom reduction and thereby broaden the determination of treatment effects has yet to be identified. In the renowned demoralization theory of Jerome Frank (e.g., 1974) and the phase model of Howard et al. (1993), the construct of remoralization is put forward to describe an important psychotherapy outcome that occurs in addition to symptom reduction. While remoralization appears to be a promising measure in addition to symptom reduction, a suitable measurement instrument (i.e., measure to document changes in remoralization) is lacking. Whether or not remoralization can be empirically distinguished from symptom reduction is also not clear. Because of this, the question remains: Is remoralization a valuable outcome measure supplementary to measuring symptom reduction in psychotherapy outcome research? In the first three empirical chapters of the dissertation (Chapters 2, 3, and 4), critical aspects of the measurement of remoralization will therefore be considered in order to determine the added value of attention to remoralization. A related but somewhat different enterprise is undertaken in the fourth empirical chapter (Chapter 5) in order to determine the treatment implications of the phase model of psychotherapy outcome.

Chapter 2. Development of the remoralization scale: An extension of contemporary psychotherapy outcome measurement

In this chapter, the newly developed Remoralization Scale (RS) is introduced. The RS has been specifically developed for patients in mental health care. The results of five studies are described. First, the development of the RS, thereafter, the unidimensionality and scalar invariance of the RS; the reliability of the RS; the construct validity of the RS; and the sensitivity of the RS to therapeutic change are investigated.

Chapter 3. Utility of measuring remoralization in addition to symptoms in efficacy research: A preliminary study

In this chapter, the results of a naturalistic study undertaken to investigate whether or not the measurement of remoralization is sensitive to changes at several points during the course of an empirically-supported treatment are reported. The relations between remoralization and symptom reduction are investigated in addition to the unique contribution of measuring remoralization in addition to symptom reduction for the prediction of change in health-related quality of life. This study was also designed to overcome the methodological drawbacks of earlier studies of the phase model of Howard and colleagues (1993). Patients suffering from a specific and well-defined disorder, namely panic disorder with agoraphobia, received an indicated, protocol-based EST. Changes in specific agoraphobic avoidance symptoms and agoraphobic cognitions, changes in remoralization, and changes in health-related quality of life were examined across the course of treatment.

Chapter 4. The distinction between remoralization and symptom reduction: An experimental study

The study reported on in this chapter was specifically designed to experimentally investigate the relations between remoralization and symptom reduction. Once again, patients suffering from panic disorder and agoraphobia were followed. Patients were randomly assigned to a waiting list control condition or one of two treatments. Both remoralization and specific panic symptoms were assessed. The effects of a brief treatment focused solely on remoralization versus the effects of a brief exposure in vivo treatment for the symptoms of the disorder were compared. This experimental research design was adopted in order to maximize the chances of distinguishing remoralization and symptom reduction. It was reasoned that, if remoralization and symptom reduction can really be distinguished as Frank (1974) and Howard et al. in the phase model (1993) both propose, the treatment aimed at remoralization should not lead to symptom reduction; conversely, the treatment aimed at remediation should not lead to increases in remoralization.

Chapter 5. Treatment implication of the phase model of psychotherapy outcome: An experimental study

The three preceding empirical studies were all designed to answer the question of whether the measurement of remoralization is valuable in addition to the measurement of symptom reduction in psychotherapy outcome research. The fourth empirical study addresses a different but related topic. Previous studies of the phase model (Barkham et al, 1996; Callahan et al., 2006; Hilsenroth et al., 2001; Holloway, 2004; Howard et al.,

1993; Joyce, et al., 2002; Kopta et al, 1994; Lutz et al., 2001; Martinovich, 1998) all suffer from an important shortcoming, namely: that all refrained from the provision of treatment in line with the content of the phase model. According to Howard et al. (1993), "certain classes of interventions are appropriate for different phases of therapy" (p. 679). In the phase model, it is indeed presumed that different topics should be addressed during different phases of therapy, but none of the studies testing the phase model to date — including that of Howard et al. — have either experimentally or quasi-experimentally, tested this presumption.

The study described in Chapter 5 was designed to do just this and thus to experimentally investigate the treatment implications of the phase model. The study is an extension of the study described in Chapter 4. The patients in the treatment condition from the study described in Chapter 4 received a second brief treatment after initial brief treatment in such a manner that half of the patients in the treatment condition received remoralization treatment first and then exposure treatment; the other half received exposure treatment first and then remoralization treatment. It was reasoned that the treatment sequence that was in concordance with the sequence of the phase model (i.e., brief remoralization treatment followed by brief symptom reduction treatment) would be more effective than the treatment that was not in concordance with the sequence of the phase model (i.e., brief symptom reduction treatment followed by brief remoralization treatment). Effects were similarly measured in terms of both symptom reduction and remoralization.

Chapter 6. Summery and general discussion

In the final chapter of this dissertation, the overall results of the studies are summarized. Limitations and considerations, and the implication of the results in relation to the background of the dissertation are discussed.

Chapter 2. Development of the Remoralization Scale

An Extension of Contemporary Psychotherapy Outcome Measurement

This chapter contains a slightly altered version of:

Vissers, W., Keijsers, G. P. J., van der Veld, W. M., de Jong, C. A. J., & Hutschemaekers, G. J. M. (in press). Development of the Remoralization Scale: An extension of contemporary psychotherapy outcome measurement. *European Journal of Psychological Assessment.*

Abstract

Remoralization is the process of restoration of morale. Remoralization constitutes an important step in the therapeutic change process. Because no appropriate self-report instrument was available to indicate the level of morale in mental health care patients, the Remoralization Scale (RS) was developed. In a first study (299 outpatients), a pool of 69 items was examined to produce an initial scale of 16 items with a unidimensional factor structure. In a second study (199 outpatients, 192 non-patients), the unidimensionality and scalar invariance of the initial scale was tested. To make the RS as short and easy to complete as possible, 4 items with low factor loadings were removed. In a third study (124 students), the test-retest reliability (r = .89) and internal consistency (α = 0.91) of the RS were estimated. In a fourth study, the construct validity of the RS was investigated using a demoralization scale (r = –.72) and scales which measure anxiety (r = –.52), depression (r = –.50), somatic symptoms (r = –.36) and social dysfunction (r = –.37). In a fifth study (24 panic outpatients), the sensitivity of the RS to therapeutic change was examined and found to be good. In closing, limitations of the RS were discussed.

Introduction

The designs of contemporary psychotherapy outcome studies draw heavily on medical treatment efficacy research. The effects of specific, manual-based treatments are typically compared to the effects of other, equally well-defined treatments or control groups. The outcome measures in efficacy research are usually measures of symptom reduction, especially in the large randomized controlled trials and meta-analyses (see, for instance, Gould, Otto, & Pollack, 1995; Westen & Morrison, 2001). Reduced symptomatology is often taken to be necessary and sufficient for the demonstration of psychotherapeutic treatment effects.

More and more, however, various authors in the area of contemporary psychotherapy have taken issue with the fact that, in line with the medical model, the main focus is on symptom reduction (Hill & Lambert, 2004; Jacobson, Roberts, Berns, & McGlinchey, 1999). The frequent hopes of patients in psychotherapy for a wider range of treatment effects is insufficiently taken into account by the medical model (Grosse Holtforth & Grawe, 2002) and successful psychotherapeutic treatment often yields more than simply a reduction of symptoms (Goldfried & Wolfe, 1996; Perkins, 2001; Wampold, 2001). Additionally, symptom reduction does not necessarily imply positive changes in, for example, the individual's subjective sense of well-being or the quality of social relationships (Mirin & Namerow, 1991). Furthermore, for a chronic mental illness such as schizophrenia, it is known that an increased sense of control and a reduction of hopelessness can be brought about despite a lack of reduced symptomatology (Strauss, 1994).

It seems clear that exclusive attention to symptom reduction is considered problematic. Other concepts that can be investigated in addition to symptom reduction in treatment outcome research are required. Several psychological concepts have been introduced over the years to describe the beneficial effects of psychotherapy besides symptom reduction. In social psychiatry, the concept of *empowerment* (Rogers, Chamberlin, Ellison, & Crean, 1997) has been put forth; in various psychotherapeutic traditions, the concepts of *ego-strength* (Kernberg et al., 1972) and *self-actualization* (Maslow, 1970) are well-known. However, these introduced concepts do not have a concise meaning outside the specific psychotherapeutic traditions in which they are embedded, which makes them less suitable as outcome measures in addition to symptom reduction. A rare exception is the concept of *demoralization*, introduced by Jerome Frank in 1974, which has significance across different psychotherapeutic approaches. Demoralization is a state of mind, resulting from a person's belief that he or she is incapable of solving problems and thus characterized by feelings of impotence, isolation, and despair. Demoralized patients feel powerless and hopeless. Frank believed that the effectiveness of every form of psychotherapy depends upon its ability to restore a patient's morale. In later work, Howard, Lueger, Maling, and Martinovich (1993)

referred to the restoration of a person's morale as 'remoralization' and asserted that remoralization may actually constitute the first step in the process of therapeutic change. Remoralization encompasses a variety of beneficial treatment effects, which makes it attractive as an outcome measure in addition to the assessment of symptoms.

Although remoralization, as is demoralization, has been discussed over the years as an interesting, promising concept, and despite the introduction of various instruments to measure demoralization and remoralization, it has barely influenced the efficacy and effectiveness outcome research. In 1980, Dohrenwend, Shrout, Egri and Mendelsohn developed the Psychiatric Epidemiological Research Interview-Demoralization. However, this instrument has several disadvantages when used as an outcome measure. First, it is an interview as opposed to an easy to administer self-report instrument. Second, it is a classification instrument which asks about demoralization during the past year, which makes it insensitive to change. Third, it contains a number of items concerned with symptoms of anxiety, depression and psychosomatic problems, which makes it less appropriate to be measured in addition to symptom assessment. In 1993, Howard et al. published a two-item scale to measure subjective well-being. However, this instrument does not encompass Frank's broader conceptualization of demoralization. Furthermore, the use of a measurement scale with only two items is methodologically limited; the reliability and the content validity of the scale can easily drop below acceptable values. In 2004, the Demoralization Scale (Kissane, Wein, Love, Lee, Kee, & Clarke, 2004) was introduced. This scale was developed to measure demoralization in general health care patients. It was only tested on a relatively small (N = 100) and highly homogeneous sample of patients suffering from chronic somatic illnesses (cancer) for its validation and no data regarding the (test-retest) reliability of the scale or confirmation of its underlying factor structure are known. In addition to the fact that the Demoralization Scale measures demoralization as opposed to remoralization, its suitability and psychometric properties for use with patients in mental health care are unknown.

To our knowledge, no appropriate instrument is available for the measurement of changes in remoralization as a result of treatment among mental health care patients. It was therefore decided to develop a new instrument. The Remoralization Scale (RS) is intended to be used during the treatment process to indicate the level of a patient's morale at the time of administration. Given that remoralization is a process, multiple measure points are obviously needed over time to determine whether the patient's morale is restoring or not. The instrument should, therefore, be an easy-to-use self-report measure with only a small number of items to minimize response burden. In addition, the instrument should be unidimensional, reliable and valid. In the present article, we thus report on the results of five studies conducted to develop and document the RS. In Study 1, the development of the scale was undertaken. In Study 2, the factor structure underlying the scale was examined. In Study 3, the test-retest reliability and

internal consistency of the scale were documented. In Study 4, the construct and discriminative validity of the scale were determined. And in Study 5, the sensitivity of the scale to therapeutic change was examined.

Study 1: Scale development

In the literature, a state of *demoralization* has been shown to relate to such concepts as (1) feelings of low self-esteem (de Figueiredo & Frank, 1982), (2) feelings of impotence (3) and absence of a sense of mastery (Frank, 1974), and (4) pessimism (Howard et al., 1993). *Remoralization* has been shown to relate to (5) a sense of inner control (Frank) and (6) restored hope (Kuyken, 2004). Obviously, these relationships are part of the conceptualizations of remoralization, rather than being established empirically. In fact, measures of the aforementioned concepts have been frequently used as proxies for the measurement of remoralization. Building upon this idea, we thus searched for instruments which measure the aforementioned concepts and expected the combination of these various instruments to provide a good starting point for the development of the RS. Whether or not a combination of such instruments measure one or more dimensions was also of interest.

Method

Several criteria were applied for the initial selection of the instruments. Substantively, each instrument had to measure one or more of the six aforementioned concepts which relate, according to the literature, to demoralization or remoralization. In addition, each instrument had to be (1) self-report, (2) brief and easy to complete and (3) sensitive to change.

Measures. We found a total of five instruments to meet the selection criteria and, given that one of the instruments measured two of the aforementioned concepts, all six of the relevant concepts were addressed. The concepts with the corresponding measurement instruments were as follows.

- Self-esteem using the Rosenberg Self-Esteem Scale (Rosenberg, 1965)
- Personal empowerment and sense of mastery using the Empowerment Scale (Rogers et al., 1997)
- General feelings of competence using the adapted Dutch version (Bosscher, Smit, & Kempen, 1997) of the General Self-efficacy Scale (Sherer et al., 1982)
- Optimism, the opposite of pessimism, using the Optimism Subscale from the Positive Outcome Scale (Appelo, 2005) and sense of inner control using the Autonomy Subscale also from the Positive Outcome Scale
- Hope using the State Hope Scale (Snyder et al., 1996)

The five instruments were next combined into a survey which contained a total of 69 items. For all instruments, except for the State Hope Scale (Snyder et al., 1996), official Dutch items were available. For the State Hope Scale we followed the back-translation procedure to obtain the Dutch items.

Participants and procedure. A sample of 750 patients, 18 years of age or older, was selected by a computerized random generator from the outpatient databases of the three main locations of *De Gelderse Roos*, a community mental health centre in the east part of The Netherlands. A package containing the survey, a demographic questionnaire, a questionnaire to inventorize reasons for seeking psychological help, and a return envelope was mailed to the selected individuals by secretaries from the different locations. No information which could possibly lead to identification of the selected patients was requested and the anonymity of the respondents was thus guaranteed. A total of 299 individuals returned sufficiently completed questionnaires (39.9%); 207 were female (69%). The age of the respondents varied from 19 to 73 with a mean of 38 years (SD = 11). Of the 299 respondents, 40 had not yet started treatment (13%), 190 were currently receiving treatment (64%) and 47 had recently completed their treatment (16%). A total of 169 respondents reported seeking treatment for feeling depressed (57%), 110 for feeling anxious (37%) and 93 for feeling tense (31%). Intake for about 25% of the respondents was more than 32 months prior to questionnaire administration. The distribution of the amount of time between intake and administration of the questionnaire is skewed to the right (skewness = 3.55) with a median of 12 months.

Results

Single-factor principal components analyses were first conducted on each of the measurement instruments separately in order to select those *three* items which best represented the concept in question. It was decided a priori to select the three items loading highest per instrument in order to avoid possible overrepresentation in the RS of scales with a relatively larger number of items. This was also a step towards minimization of the number of items in the RS. The resulting set of 18 items contained two items with a strong overlap in their wording: 'I have a positive attitude towards myself' (Empowerment Scale) and 'I take a positive attitude towards myself' (Rosenberg Self-Esteem Scale). It was therefore decided to omit the item from the Empowerment Scale.

Next, an exploratory factor analysis was conducted on the set of 17 remaining items using maximum likelihood estimation to determine the number dimensions measured. When the scree plot was examined (Floyd & Widaman, 1995), an elbow was fairly apparent and thus showed a one-factor solution to yield the best fit. The factor has an eigenvalue of 6.77 and explanation of 42.30 % of the variance in the item scores. 'When I have something unpleasant to do, I stick to it until the task is finished' (Self-Efficacy Scale) was omitted following the rule of thumb which requires items with a loading under .40 to be discarded (Guadagnoli & Velicer, 1988). The Cronbach's alpha

used to assess the internal consistency of the scale was .92 (n = 266). In the next step in the development process (Study 2), confirmatory factor analyses were undertaken to show that the 16 items indeed formed a unidimensional scale.

Study 2: Scale confirmation

Study 2 had two objectives. The first objective was to show the 16 items from Study 1 to again load on a single factor. The second objective was to see if the RS measures the same construct in the same way for both patients and non-patients. Ideally, patients are non-patients by the end of their treatment (Jacobson et al., 1999) and the RS should be applicable throughout the treatment process to document changes in morale. That is, it should be possible to compare RS scores over time (i.e., from the very start of treatment to the end of treatment). Both objectives are met by a multi-group confirmatory factor analysis.

Method

Participants and procedure for the patient sample. A total of 199 outpatients from either *De Gelderse Roos* community mental health centre (no overlap with the sample in Study 1) or the *GGZ Nijmegen* community mental health centre (Nijmegen, The Netherlands) volunteered to participate in the present study after being invited to do so at intake (participation rate of 88.5%). The age of the participants varied from 21 to 60 years with a mean of 38 (SD = 11); 121 participants were female (61%). With the exception of the patients requiring outpatient mental health care, no exclusion criteria were applied. Those patients who agreed to participate were asked to provide some demographic information and complete the RS16. As in Study 1, participants were anonymous to the researchers.

In order to be sure that the sample consisted of patients suffering from mental health problems at the time of data collection, assessment was undertaken immediately following intake. Given that the original five measurement instruments employed different response formats, a single response format was provided for the 16 items. That is, a four-category scale ranging from *totally disagree* to *totally agree* was used by the participants to respond.

Participants and procedure for the non-patient sample. A 'snowball sampling' procedure (Faugier & Sargeant, 1997) resulted in 192 participants, not seeking mental health care, referred in the present study as non-patients. Snowball sampling relies upon referrals from initial subjects to generate additional subjects. This technique was used on account of time and money constraints. The age of the non-patients varied from 18 to 91 years with a mean of 37.32 (SD = 13.57); 124 participants

were female (65%). Three of the non-patients reported a somatic illness (1.6%) and six reported having a mental illness (3.2%).

Individuals received an e-mail letter in which the aims of the study were described and the recipient was invited to participate in the study. The participants were mailed a survey packet which consisted of a demographic questionnaire, the RS16 and two other self report instruments being used to validate the RS (see Study 3).

Data analyses. Given that the RS is to be used across time to track changes in the level of morale, the scale should be scalar invariant. We tested for this using a procedure suggested by Meredith (1993). The procedure starts with the most simple form of invariance (factorial and metric) and ends with the most strict form of invariance (scalar). While the current practice is to evaluate model fit using fit indices and the *RMSEA* in particular, recent studies have shown fit indices with fixed critical values (e.g., the *RMSEA*, *GFI*) are not able to control for type I and type II errors (Marsh, Hau, & Wen, 2004; Saris, Satorra, & van der Veld, 2009). An alternative procedure, namely *the detection of misspecifications* (Saris et al.), was therefore adopted to evaluate the fit of the model developed. The procedure departs from fit indices to evaluate model fit and returns to exact tests while controlling for type I and type II errors. The idea behind the procedure is that each constrained model parameter can be a misspecification. The traditional procedure used to determine if a constrained parameter is perhaps a misspecification, the use of the modification index, is sensitive to the power of a test. For this reason, we controlled for that. The power of the test to detect a misspecification of size delta or larger can be computed using a special formula (Saris et al.). The size of delta depends upon the size of the misspecification one wants to detect with high power and can thus be set by the researcher. Whether or not a constrained parameter is a misspecification is judged from the combination of the power, which can be high or low, and the modification index, which can be significant or not. There is a misspecification when either the power is low and the modification index is significant or the power is high, the modification index is significant and the expected parameter change is larger than delta. Other combinations indicate no misspecification or a lack of power to detect a misspecification. For the current analyses, we set the alpha level at .05, the power at .80 and the delta at .10.

Results

The factorial invariance of the RS16 was first evaluated. The model contained many large misspecifications (*RMSEA* = .10, χ^2 = 529, *df* = 208). We improved the model in a stepwise manner by deleting those items with a standardized loading lower than .40 from either the patient or the non-patients sample. If no such items occurred further but major misspecifications were still found, correlated errors, which could be given substantive meaning and were present in both the patient sample and the non-patient

sample, were introduced. Following these rules, four items had to be removed from the RS, which produced an acceptable model (*RMSEA* = .07, χ^2 = 183, *df* = 100). The final form of the RS thus contained 12 items and is presented in the Appendix. This form of the RS also showed metric invariance (*RMSEA* = .07, χ^2 = 204, *df* = 111). Finally, whether or not the final version of the RS is scalar invariant was also tested. The model contained one important misspecification which was fixed. The resulting model was good (*RMSEA* = .07, χ^2 = 232, *df* = 121). It can be concluded that patients and non-patients understand the items of the RS similarly. As a consequence, their scores can be compared.

Study 3: Scale reliability

Study 3 had two objectives. The first objective was to investigate the test-retest reliability of the RS. The changes to be tracked by the RS over time should be clearly the result of actual changes in the level of morale and not due to random measurement error. A high level of test-retest reliability is thus required. This was tested for with a student sample for which no systematic changes in morale could be expected, particularly within a brief period of time; any changes detected using the RS could thus be attributed to random error.

The second objective was to assess the internal consistency of the RS. The Cronbach's alpha for the initial RS (i.e., the RS16) was .92 (*n* = 266). In Study 2, four items were omitted, but the internal consistency should not decrease too much as a result of such deletion.

Method

Participants and procedure. For determination of the test-restest, a sample of 124 psychology students was recruited and asked to complete the RS at the end of a seminar on two consecutive occasions with one week in between the administrations. The mean age of the respondents was 22 years (*SD* = 3.2), and 102 respondents were female (82%).

The Cronbach's alpha for the psychology students described above and for the patients and non-patients described in Study 2 were estimated.

Results

The Pearson correlation between the first and second administrations of the RS in the student sample was estimated. The test-retest reliability of the RS was found to be .89 ($p < .01$, n = 124, time 1: M = 3.11, SD = 0.39; time 2: M = 3.10, SD = 0.39), which is good.

The Cronbach's alphas for the patient sample, the non-patient sample and the student sample were .91 (n = 177), .91 (n = 166) and .87 (n = 123), respectively. The internal consistency of the RS was thus high and similar across different samples. In addition, the removal of the four items as described in Study 2 was found to have only a negligible to marginal effect on the internal consistency of the RS.

Study 4: Scale validity

Study 4 was conducted to investigate the validity of the RS. To start with, the capacity of the RS to differentiate between patients and non-patients was examined. That is, the levels of remoralization for the different groups were investigated and compared.

Second, the construct validity of the RS was investigated by examining the relations of the RS to other relevant concepts for mental health care patients. The following concepts were chosen for this purpose: demoralization, somatic symptoms, social dysfunction, anxiety and depression. Remoralization is described in the introduction as the reduction of demoralization and we hence expect a strong negative correlation to occur between the constructs of remoralization and demoralization. Somatic symptoms and social dysfunction were expected to be related to, but nevertheless clearly distinguishable from, the level of remoralization; that is, moderate negative correlations were expected to occur with the RS. Demoralization and remoralization are intrapsychic, just as feelings of anxiety and depression. Highly anxious or depressed people often feel quite demoralized (Frank, 1974). Conversely, being demoralized can make people more fearful of losing control and going crazy which may then, in turn, make them more vulnerable to depression and other dysphoric emotions (Frank). For this reason, strong negative correlations were expected to occur between remoralization, anxiety and depression. In this light, several scholars have questioned whether depression and demoralization can be treated as distinct concepts because they both accompany symptoms of distress, despair, impotence, hopelessness and loss of meaning (Mangelli et al., 2005). However, it has been shown that demoralization and depression can indeed be clearly distinguished (Clarke, McLeod, Smith, Trauer, & Kissane, 2005; Mangelli et al.).

Method

Participants and procedure. See Study 2.

Measures. The Demoralization Scale (DS) of Kissane and colleagues (2004) consists of 24 items to be scored along a five-point scale. The following five dimensions of demoralization are distinguished: disheartenment, loss of meaning, non-specific dysphoria, helplessness and sense of failure. DS total score is an addition from all items of the DS. High scores on the DS indicate strong demoralization. The Dutch adaptation

(Koeter & Ormel, 1991) of the General Health Questionnaire (GHQ; Goldberg, 1972) measures somatic symptoms, social dysfunction, anxiety and depression. The GHQ consists of 28 items to be evaluated along a four-point scale. High GHQ scores indicate high levels of psychopathology.

Results

We tested whether the mental health patients produced, on average, lower RS scores than the non-patients in an ANOVA. The results showed the patients to be significantly less remoralized (M = 2.37, SD = 0.57) than the non-patients (M = 3.33, SD = 0.45), F (1, 356) = 309.74, $p < .001$, Cohen's d = 1.87.

Pearson correlations were calculated between the RS, the DS and the subscales of the GHQ. The estimates confirmed our expectations. According to the conventions of Cohen (1987) for the interpretation of correlations: $r > .30$ is moderate and $r > .50$ is high. The RS showed high negative correlations with the DS (r = –.72), GHQ anxiety (r = –.52) and GHQ depression (r = –.50). The RS showed moderate negative correlations with GHQ somatic symptoms (r = –.36) and GHQ social dysfunction (r = –.37).

Study 5: Sensitivity to change

A longitudinal study was undertaken in order to investigate the sensitivity to change of the RS among 24 patients suffering from a panic disorder with agoraphobia.

Method

Participants and procedure. A total of 42 patients from the outpatient clinic for anxiety disorders of the Pro Persona Centre for Anxiety Disorders *Overwaal* were invited at intake to participate in the present study when they met below mentioned criteria. After referral for treatment, two intake sessions were conducted conform normal procedure. The Mini International Neuropsychiatric Interview (Lecrubier et al., 1997) was examined in order to classify the problems of the patients in terms of DSM-IV diagnoses. Inclusion and exclusion criteria for the present study were determined at this time in line with the usual criteria of *efficacy* studies on PDA (Westen & Morrison, 2001). The inclusion criteria were: (1) a present classification of panic disorder with agoraphobia (PDA), and (2) age between 18 and 65 years. The exclusion criteria were: (1) receipt of other psychological treatment, (2) use of effective antidepressant medication or (3) a present diagnosis of schizophrenia, mental retardation, suicidal ideation, alcohol or psychoactive substance abuse or dependence. Since a reduction of symptoms in depressed patients could erroneously be attributed to an increase in remoralization, patients meeting the DSM-IV criteria for a mood disorder were also

excluded. When selected for inclusion in the study, the participants were asked to provide their informed consent and a postal address. Survey packets containing the instruments, a demographic questionnaire and a return envelope were mailed to the selected individuals prior to the initiation of their treatment. After 28 weeks, a second survey packet was mailed.

The usual procedure followed at the outpatient clinic for patients taking antidepressant medication which is proving ineffective, is to discontinue medication under supervision of a psychiatrist. After a washout period of two weeks and prior to the start of other treatment, such patients were asked to participate in the present study. Patients taking benzodiazepines were asked to adhere to a set daily dosage during the course of the present study. Of the patients initially approached, 11 did not participate further due to refusal to participate or because they wanted to continue with their ineffective antidepressant medication or refused to set their benzodiazepine use. A total of 31 patients enrolled in the study. Of these, 6 used benzodiazepines and agreed to adhere to a fixed dose. During the study, 7 patients dropped out for reasons of being too busy or failed to return the questionnaire and could not be contacted thereafter (23%). Of the 24 completers, 17 were female (71%). The age of the respondents varied from 22 to 50 years with a mean of 32 (SD = 9.29).

Treatment. Patients received evidence-based treatment which drew upon the Dutch multidisciplinary guidelines for anxiety disorders (Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling in de GGZ, 2003). This could be either (a) panic control treatment (PCT; Craske & Barlow, 1993) or (b) treatment with Citalopram which is a Selective Serotonin Reuptake Inhibitor in combination with supportive consults with a psychiatrist.

Measures. In addition to the utilization of the RS, the effectiveness of the treatment being followed for the reduction of the symptoms of PDA was checked using the Mobility Inventory Avoidance when Alone (Chambless, Caputo, Jasin, Gracely, & Williams, 1985).

Results

When the effectiveness of treatment was examined with respect to symptom reduction, the results showed the patients to be significantly less avoidant at week 28 (M = 1. 78, SD = 0.68) than at the start of the study (M = 2.70, SD = 0.83), F (1, 23) = 35.46, $p < .001$, Cohen's d = 1.21. The next question, of course, was whether an effective treatment for a panic disorder could also foster remoralization as well, and this was in fact found to be the case. The change in the RS scores was found to be significant: M = 2.64 (SD = 0.36) at the start of study as opposed to M = 3.30 (SD = 0.50) after 28 weeks (F [1, 23] = 56.93, $p < .001$, Cohen's d = 1.51). These data suggest that the RS is indeed sensitive to therapeutic change.

General discussion

In a series of empirical studies, the RS was developed and tested. The initial pool of items used for this purpose was derived from already available instruments with content related to remoralization or demoralization. In the five studies presented here, the RS was shown to be unidimensional self-report instrument with high internal consistency, excellent test-retest reliability, both good construct validity and discriminative validity for patients versus non-patients and sensitivity to therapeutic change. With only 12 items, the RS is brief and easy to interpret. The unidimensional structure of the RS suggests that it indeed measures a single concept which was initially documented for a large group of mental health patients in an exploratory factor analysis and later confirmed for both mental health patients and non-patients.

The RS further showed a strong negative correlation (-.72) with the DS (Kissane et al., 2004), indicating considerable overlap between the two instruments. This raises the question — in retrospect — of whether the DS might be used to meet the same aims as the RS. When the nature of the two measurement instruments is compared more carefully, it should first be noted, as written in the introduction, that the DS was tested in one study using only preliminary data of somatic care patients. The RS, in contrast, has been tested extensively in the five studies presented here, using several samples including a wide variety of mental health care patients as well as non-patients. Second, the RS is unidimensional and contains only 12 items which makes it easy to administer in repeated measures outcome research. The DS, in contrast, contains twice as many items and is multidimensional with five highly correlated dimensions (in the present data ranging from .36 $p < .01$ to .71 $p < .01$). This makes the DS more difficult to administer and interpret in actual practice than the RS. Finally, the DS measures a negative state and therefore emphasizes what is wrong. This may work demoralizing in and of itself, particularly when the instrument is administered repeatedly during the course of treatment. The RS, in contrast, measures a positive state.

One possible limitation on the present series of studies concerns the selection of items for inclusion in the original item pool. It was decided a priori to include those three items which best represented each of the concepts measured by six scales judged to be of relevance for remoralization in the original RS item pool. This decision was based on both theoretical and practical considerations. One can argue, however, that a factor analysis on the 69 items from the original scales *combined*, as opposed to per scale, with subsequent selection of those items with the highest factor loadings from the total, might have been a more appropriate method for item selection. We determined whether the same 12 RS items would be included when a factor analysis was conducted on the original 69 items *together* and those 18 items with the highest factor loadings then selected for further consideration. Of the 12 items constituting the RS, 11 would again be selected. Furthermore, examination of the scree plot for the factor analysis on

the original 69 items together also showed a one-factor solution to best fit the data. This finding suggests that patients do not construe the concepts of self-esteem, empowerment, self-efficacy, optimism, autonomy and hope — as reflected by the original 69 items — as highly different. In addition, it was argued in the introduction that the concept of remoralization captures an interesting variety of beneficial treatment effects other than symptom reduction. The present findings appear to provide support for this argument: The concepts of self-esteem, empowerment, self-efficacy, optimism, autonomy and hope are not only theoretically but also empirically related to the concept of remoralization.

Some other possible limitations on the present studies concern the manner of data collection. For reasons of anonymity, the avoidance of interference in the treatment process of participation in the research, we had no direct contact with the patients in Studies 1 and 2. This allowed only limited insight into the demographic and psychiatric characteristics of the patients. In Study 1, the secretaries from *De Gelderse Roos* mailed the instruments to the patients. Without any obligation to respond and no follow-up steps for non-response, the response rate stagnated at less than 40%. This limits the generalizability of the present results to other outpatients in mental health care. The participants, moreover, completed the instruments in an uncontrolled setting with possible assistance and/or influence from others. Future research on the RS should thus adopt a more sophisticated data collection procedure to overcome some of these problems.

The snowball sampling procedure which was used to select the non-patients of Study 2 suffers from the same disadvantages as mentioned above. However, the disadvantages are less important here because it was not our intention to test the RS in a representative nonclinical sample. Our main interest was to see if non-patients understand the items similarly to the patients and whether the former score higher on the RS than the latter. Scalar invariance tests indicate the comparability of the non-patients and patients, which makes comparisons of the mean scores for such groups valid and meaningful. In addition, the non-patients showed higher mean scores than the patients.

In Study 5, we showed the RS to be sensitive to therapeutic change for a small group of patients suffering from panic disorder with agoraphobia. Whether the RS is similarly sensitive to therapeutic change, and thus useful, for other groups of patients obviously requires further investigation. For now, the RS appears to be clearly sensitive to change, also because it discriminated between patients and non-patients.

The analyses and results presented here are tentative to some extent, but show the RS to be a promising instrument for the assessment of remoralization in mental health care patients receiving psychotherapy. The next step in our research is to examine the relations between symptom reduction and remoralization as a result of psychotherapy. As argued in the introduction, contemporary outcome research tends to focus

heavily on the reduction of symptoms as a means to document the effectiveness of psychotherapeutic treatment. There is nevertheless good reason to believe that successful treatment also realizes remoralization. And only when additional treatment effects are taken sufficiently into account can the effects of psychotherapeutic treatment be fully appreciated.

Chapter 3. Utility of Measuring Remoralization in Addition to Symptoms in Efficacy Research

A Preliminary Study

This chapter contains a slightly altered version of:

Vissers, W., Keijsers, G. P. J., van der Veld, W. M., Hendriks, G. J., & Hutschemaekers, G. J. M. (in press). Utility of measuring remoralization in addition to symptoms in efficacy research: A preliminary study. *Psychotherapy Research*.

Abstract

Remoralization as an outcome measure for psychotherapy was compared to symptom reduction (agoraphobic avoidance and -cognitions). Twenty-four patients with panic disorder and agoraphobia received empirically-supported treatment and were followed across multiple time-points for 28 weeks. Treatment resulted in reduced symptoms and enhanced remoralization (Cohen's *d*s 1.19 to 1.45). Slopes of symptoms and remoralization were obtained from latent growth model analyses. The slopes correlated highly ($r = -.50$ to $-.55$), which indicates similar patterns of change over time. The slope of remoralization also correlated with a number of aspects of health-related quality of life, while the slope of symptom reduction did not. Though strongly related to symptom reduction, the measurement of remoralization is expected to provide unique information for treatment *efficacy* research.

Introduction

Since the first edition of *Persuasion and Healing* by Jerome Frank in 1961, therapists have grown to appreciate the essential features of the demoralization theory. The many reprints of *Persuasion and Healing* show how successful the message was. Demoralization theory states that people who enter into treatment for psychological problems do not only suffer from a specific mental disorder (i.e., symptomatic burden) but typically feel demoralized as well. Frank (1974) believed that the painful experience of symptoms and accompanying negative emotions over longer periods of time, leads to feelings of hopelessness and powerlessness, central to the state of demoralization. Demoralization results from an individual's belief of being incapable of solving current problems and is thus characterized by feelings of impotence, isolation, and despair. According to Frank the effectiveness of every form of psychotherapy depends upon its ability to restore a patient's morale. In writings of Howard, Lueger, Maling, and Martinovich (1993), the expression *remoralization* refers to the process of restoration of morale and is believed to take place in an early phase in psychotherapy. In this phase the problems of the patients are acknowledged, the therapist offers an understanding of the patients' suffering and instils hope by showing that there are ways in reducing it. These ingredients of the first psychotherapy sessions lead to remoralization by stimulating positive growth, an increase of hope, a sense of mastery, and an increase of subjective well-being.

Given the impact of the work of both Frank (1973) and Howard et al. (1993) on academic views of psychotherapy, one would expect remoralization to be a valuable measure as part of the assessment of treatment outcome in psychotherapy outcome research. However, in the current research generation, in which well-documented treatments are evaluated on their effects on specific disorders (see e.g., Godfried & Wolfe, 1996), remoralization is no part of the assessment. In this, so called *efficacy* research, remoralization is rarely used as an outcome measure. And the question is, of course, why?

Perhaps the most important reason for the lack of attention to remoralization as outcome measure is that the added value of measuring remoralization in addition to the measurement of symptom reduction has remained unclear. Symptom reduction has been the primary outcome measure in efficacy research over the past few decades. In large randomized controlled trials and meta-analyses, symptom reduction is considered the only relevant outcome (see, for instance, Gould, Otto, & Pollack, 1995; Westen & Morrison, 2001). And while Frank (1974) asserted that the process of remoralization can be theoretically differentiated from the process of symptom reduction, he — himself — never investigated this assertion empirically. Howard and colleagues similarly described changes in remoralization and symptom reduction as two distinguishable processes, and a number of studies were conducted along these lines (e.g. Callahan,

Swift, & Hynan, 2006; Grissom, Lyons, & Lutz, 2002; Hilsenroth, Ackerman, & Blagys, 2001; Howard et al., 1993; Lutz, Lowry, Kopta, Einstein, & Howard, 2001, Lutz, Martinovich, & Howard, 1999), but these studies did not directly investigate, nor provide specific information on the relationship (correlation) between remoralization and symptom reduction. Further, most of the these studies have used unspecified patient samples, unspecified treatments or treatments directed on all kind of problems and syndromes, and/or general symptom checklists which were insufficiently suited to separate symptom reduction from remoralization. Hence, it is unclear whether remoralization and symptom reduction might considerably overlap or might be two, maybe somewhat related, but rather different measures of outcome.

Presently, we do not know whether measuring change in remoralization ads extra information that is useful, or even highly desirable, for the proper evaluation of psychotherapy outcome in efficacy research, when measured in addition to symptom reduction. To fill in this gap of knowledge, a study was undertaken in which patients suffering from panic disorder with agoraphobia were given indicated, manual-based, empirically-supported treatment (EST) and then followed to assess their treatment outcome. Changes in specific agoraphobic avoidance and agoraphobic cognitions symptoms, changes in remoralization, and changes in health-related Quality of Life (QoL) were measured. The first aim of the study was to investigate whether or not the measurement of remoralization is sensitive to change when administered at several points during the course of the EST and thereby gain insight into the manner in which remoralization may change over time (e.g., whether increases in remoralization are linear and relatively stable over time). Given the paucity of data regarding the relationship between symptom reduction and change of remoralization as a result of treatment, the second aim of the present study was to investigate this relationship empirically. Based on the assumption that ESTs will generally lead to reduced symptomatology, the question is whether increase in remoralization will be similarly paced as symptom reduction. The third and main aim of this study was to determine if the measurement of remoralization in addition to symptom reduction offers unique information with regard to the change on health-related QoL or, in other words, the extent to which the daily life functioning of a patient is hampered by his or her problems. Given that remoralization refers to a state of mind that results from an individual's belief of being incapable of solving current problems, we expected changes in remoralization to be more strongly associated with changes in health-related QoL than symptom reduction is found to be.

Method

Participants and procedure

A total of 42 patients from the outpatient clinic for anxiety disorders at the Pro Persona Centre for Anxiety Disorders *Overwaal*, were invited at intake to participate in the present study. In order to asses the DSM-IV classification of their disorders, the Mini International Neuropsychiatric Interview (MINI; Lecrubier et al., 1997) was administered to all of the patients. The inclusion criteria for the present study were: a present classification of panic disorder with agoraphobia (PDA) and an age between 18 and 65 years. The exclusion criteria were: current receipt of other psychological treatment, use of antidepressant medication, or a present diagnosis of schizophrenia, mental retardation, suicidal ideation, alcohol or psychoactive substance dependence or abuse. Given that a reduction of symptoms on the part of depressed patients in particular can erroneously be attributed to an increase in remoralization, patients meeting the DSM-IV criteria for a mood disorder were also excluded. In accordance with standard procedure at the outpatient clinic, a multidisciplinary intake team assigned the patients to either panic control treatment (PCT) or medication treatment (MT; see Treatments and therapists section for details), in which the treatment preference of the patients was taken into account.

When selected for inclusion in the study, the participants were asked to provide their informed consent and a postal address. The participants were next administered a number of measures every four weeks across a period of 28 weeks (see Measures for a description of the measures). That is, assessment was undertaken prior to treatment (i.e., in week 0) and was repeated in weeks 4, 8, 12, 16, 20, 24, and 28. Survey packets containing the symptomatology and remoralization measurement instruments and a return envelope were thus mailed to the participants; a demographic questionnaire was also included in the packet for week 0; and a measure of health-related QoL was included in the packets for weeks 0 and 28 (see Measures).

The usual procedure at the outpatient clinic for patients taking antidepressant medication that is proving ineffective is to discontinue the medication under the supervision of a psychiatrist. After a washout period of two weeks and prior to the start of the treatment, such patients could thus be asked to participate in the present study. Patients taking benzodiazepines were asked to adhere to a set daily dosage during the course of the present study.

Of the 42 patients initially approached, 11 did not participate either because they did not want to participate, they wanted to continue with their ineffective antidepressant medication, or they refused to set their benzodiazepine use. A total of 31 patients thus participated in the study (17 assigned to PCT and 14 assigned to MT). During the study, of seven participants (23%; in PCT: 3 [18%]; in MT: 4 [29%]) we had missing data because they stopped returning the measurement packets. Some reported they were too

busy to fill in any measurements, others, could not be contacted thereafter. Twenty-four patients completed the 28 weeks of the study. Note, however, that in five casus treatment was ended before the period of 28 weeks (the distribution was as follows: for PCT 1 by week 16, 1 by week 20, 2 by week 24, and 1 by week 28) because the patients concerned had already achieved recovery. There were no treatment dropouts from MT and no treatment dropouts from PCT due to other reasons.

Of the 24 completers, 14 received PCT and 10 received MT. Seventeen participants were female (71%; in PCT: 8 [57%]; in MT: 9 [90%]). The age of the participants varied from 22 to 50 years with a mean of 32.38 years (*SD* = 9.29; in PCT: *M* = 29.07, *SD* = 7.27; in MT: *M* = 37.00, *SD* = 10.18). Fourteen participants (58%; in PCT: 8 [57%]; in MT: 6 [60%]) were living together with a partner or were married, nine participants (38 %; in PCT: 6 [43 %]; in MT: 3 [30 %]) were living alone, one participant (4 %; in MT: 1 [10 %]) was divorced and living alone. Two participants (8 %; in MT: 2 [20 %]) had low education, 9 participants (38 %; in PCT: 2 [14 %]; in MT: 7 [70 %]) had middle education, 7 participants (29 %; in PCT: 5 [36 %]; in MT: 2 [20 %]) had higher education, and 6 participants (25 %; in PCT: 5 [36 %]; in MT: 1 [10 %]) had university. Of the completers, 12 (50 %, in PCT: 8 [57 %]; in MT: 4 [40 %]) were fulltime or part-time employed, 6 (25 %; in PCT: 4 [29 %]; in MT: 2 [20 %]) were studying, 3 (13 %; in PCT: 2 [14 %]; in MT: 1 [10 %]) were unemployed (i.e. without a job or disabled); for 3 participants (13 %; in MT: 3 [30 %]) employment status was unknown.

Since panic onset, the average duration of panic symptoms was 5.45 years (*SD* = 6.92, range from 0.30 to 20.00; in PCT: *M* = 4.99, *SD* = 6.47, range from 0.42 to 20; in MT: *M* = 6.71, *SD* = 8.99, range from 0.30 to 20.00). Fourteen participants (58%; in PCT: 9 [64 %]; in MT: 5 [50 %]) had no other DSM-IV classification than DPA. Ten participants (42 %) had at least one DSM-IV Axis-I co-morbid diagnosis. The distribution was: generalized anxiety disorder 4 (3 in PCT, 1 in MT), hypochondria 3 (1 in PCT; 2 in MT), social phobia 1 (MT), specific phobia 1 (PCT), adjustment disorder 1 (MT). Further, no one had a co-morbid personality disorder. Three participants (13 %; in PCT: 1 [7 %]; in MT: 2 [20 %]) were using benzodiazepines and adhered to a set daily dosage.

Measures

In order to examine change of symptomatic burden, agoraphobic avoidance and agoraphobic cognitions were measured. Agoraphobic avoidance was assessed with the Dutch translation of the Mobility Inventory Avoidance when Alone (MI-AAL; Chambless, Caputo, Jasin, Gracely, & Williams, 1985). It consists of 25 situations typically avoided or endured with severe distress by agoraphobics. Patients rate the degree of avoidance on a five-point scale, when exposed to the situation being alone. The MI-AAL, and also the Dutch translation, have good test-retest reliability (*r*s range

from .70 to .90), high internal consistency (αs range from .91 to .97), and reasonable concurrent validity (de Beurs, 1993; Chambless et al.).

Agoraphobic cognitions were assessed with the Dutch translation of the Agoraphobic Cognitions Questionnaire (ACQ; Chambless, Caputo, Bright, & Gallager, 1984). This questionnaire contains 14 catastrophic thoughts such as 'having a heart attack' or 'losing control.' Patients rate the frequency of being troubled by these thoughts when they are anxious on a five-point scale. Internal consistency (Cronbach's αs range from .72 to .84), test-retest reliability (*r*s range from .71 to .80) of the ACQ and Dutch translation are good (de Beurs, 1993).

The Remoralization Scale (RS; Vissers, Keijsers, van der Veld, de Jong, & Hutschemaekers, in press) was used to measure remoralization. The RS is a psychometrically sound, self-report instrument that measures growth of hope, subjective well-being, and sense of mastery. Patients rate on a four-point scale the extent to which they agree with each of 12 statements. Internal consistency (Cronbach's $\alpha = .91$) and test-retest reliability ($r = .89$) are excellent (Vissers et al.).

The RAND-36 (van der Zee & Sanderman, 1994) was used to measure health-related QoL. The 36-item RAND-36 encompasses the following eight subscales: physical functioning, social functioning, role limitations due to physical problem (i.e., problems with work or other daily activities as a result of physical health problems), role limitations due to emotional problem (i.e., problems with work or other daily activities as a result of emotional problems), mental health, vitality (i.e., feelings of energy/tiredness), bodily pain, and general health perception. Internal consistency (Cronbach's αs range from .71 to.92) is good and test-retest reliability (*r*s range from .58 to .82) is reasonable (van der Zee & Sanderman).

Treatments and therapists

For our purposes we wanted to investigate patients receiving an empirically supported treatment for patients suffering from PDA to ensure a reduction of symptoms. Two treatments, Panic Control Treatment (PCT; Craske & Barlow, 1993) and medication treatment (MT) with a Selective Serotonin Reuptake Inhibitor (SSRI), are found highly and equally effective (e.g., Oei, Llamas, & Devilly, 1999; van Balkom et al., 1997). Both treatments are recommended as first choice treatments according to the Dutch national multidisciplinary guidelines for the treatment of anxiety disorders (DMG-AD; Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling in de GGZ, 2003). Of the 24 completers, 14 received PCT and 10 received MT, consisting of prescription of citalopram (which is an SSRI). For PCT, the therapists were experienced psychologists (MSc level) who were cognitive behavior therapists, and graduate students in clinical psychology working as trainees at the outpatient clinic. They all had been extensively trained in the PCT. Throughout the study period the therapists were weekly supervised by senior therapists certified as supervisors by the Dutch Association for Behavioural

and Cognitive Therapy to safeguard adequate application of the PCT techniques and adherence to the manual. Per session the therapists recorded which PCT components had been addressed and discussed these and any deviations from the manual with their supervisors. Adaptation to the intervention to meet a patient's specific circumstances were allowed if they were not in conflict with the manual. Patients received weekly sessions of 45 minutes. For MT, patients received monthly consults of 20 minutes by a licensed and experienced psychiatrist.

Results

We first performed a one-way MANOVA to test whether PCT and MT produced systematically different pre-post (Week 0 - Week 28) outcomes for the three dependent variables. The overall test yielded no significant Wilks' Lambda, F (2, 23) = 0.31, p = .82. The two treatment alternatives were therefore further taken to constitute a single EST in the analyses and interpretation of the data. An alpha level of .05 was used for all statistical tests. Whether or not treatment reduced symptomatology and promoted remoralization was examined to start with. The findings in Table 1 show the participants to be significantly less avoidant, have significantly fewer agoraphobic cognitions, and be significantly more remoralized, when the results in week 28 were compared to those in week 0 (i.e., prior to the start of the EST). The effect sizes (Cohen's $d = [M_0 - M_{28}]/SD_{pooled}$; $SD_{pooled} = \sqrt{[(SD^2 + SD^2)/2]}$) showed the changes to be robust.

Table 1
Means, Standard Deviations, F-statistics, and Effect Sizes for Pre- and Post-measurement (Week 0 vs. Week 28), n = 24.

Measure	M_{week0} (SD)	M_{week28} (SD)	F	df	p	Cohen's d
MI-AAL	2.70 (0.83)	1.78 (0.68)	35.46	23	< .001	1.21
ACQ	2.17 (0.60)	1.52 (0.49)	32.03	23	< .001	1.19
RS	2.64 (0.36)	3.27 (0.50)	56.93	23	< .001	1.45

Note. MI-AAL = Mobility Inventory - Avoidance when Alone, ACQ = Agoraphobic Cognition Questionnaire, and RS = Remoralization Scale.

Recall that the first aim of the present study was to investigate the sensitivity of a measure of remoralization to therapeutic change over time. Latent growth models (LGMs; Curran & Hussong, 2003; Duncan & Duncan, 2004) were used for this purpose because LGMs simultaneously examine changes in the variances, covariances, and mean values of factors over time. More information is thus incorporated into a LGM

than into such traditional statistical measures as a repeated measures ANOVA. LGMs also allow us to track individual changes as well as aggregate changes over time. Mplus (Muthén & Muthén, 2007) was used to estimate the LGMs. The sample size imposes constraints on the power of the test, however, Muthén and Muthén (2002) showed that a sample of 40 cases with four measures over time, yielded enough power. We have more measures over time (i.e. eight), therefore we estimated 24 casus to be enough to obtain sufficient power.

Table 2
Means, Variances, and Fit Measures for the Slopes and Intercept Factors for the MI-AAL, ACQ, and RS.

	Intercept factor		Slope factor		Fit Measures	
	M	Variance	*M*	Variance	χ^2	*df*[a]
MI-AAL	2.66*	0.74*	–0.13*	0.02*	50.50	31
ACQ	2.03*	0.29*	–0.07*	0.01*	28.10	30
RS	2.64*	0.10*	0.09*	0.00*	46.50	30

Note. RS = Remoralization Scale, MI-AAL = Mobility Inventory - Avoidance when Alone, and ACQ = Agoraphobic Cognition Questionnaire.
[a]The number of *df* for the random effects model was 31, however, for ACQ and RS an extra correlated error had to be introduced, consuming one *df*.
*$p < .05$

A random effects model was initially adopted to assess linear growth. The fit measures presented in Table 2 indicate that the random effects model fits reasonably well ($p > .01$). The change in RS (i.e., the mean for the slope factor) was significant, which shows remoralization to be sensitive to the changes that occur across multiple time points. Agoraphobic avoidance (MI-AAL) and agoraphobic cognitions (ACQ) also showed significant change over time. In addition, significant differences between the individual participants were indicated by significant variances of the intercept factors.

We have addressed the issue of power by using JRule (Saris, Satora, & van der Veld, 2009) and found for all means of the slope factors the power to detect a misspecification of .10 was .75 or higher. For the variance of the slope factors, the power to detect a misspecification of .01 was .99. Hence, our estimation that 24 casus was enough, seemed justified.

Due to the limitations of a small sample size on the number of parameters that can be estimated in a conditional LGM, the LGM could not be used to investigate the second and third research questions in the present study. The factor scores of the growth factors — intercept and slope — were therefore saved as new variables for the analyses to follow. However, because our main interest is change we only used the slope factor scores in subsequent analysis.

The second aim of this study was to investigate the strength of the relation between changes in remoralization, on the one hand, and symptomatology, on the other hand. The changes in remoralization, agoraphobic avoidance and agoraphobic cognitions were all linear. The slope of the RS scores strongly correlated with the slope of the MI-AAL scores ($r = -.50$, $p < .01$) and the slope of the ACQ scores ($r = -.55$, $p < .05$), which shows remoralization to change at a pace that is similar to the pace of change found for the symptom variables. The slopes of the MI-AAL and ACQ scores also correlated highly ($r = -.66$, $p < .01$).

The third and main aim of the present study was to investigate the unique value of measuring remoralization in addition to symptom reduction. Linear regression analyses were undertaken to determine just how well changes in remoralization, changes in agoraphobic avoidance and changes in agoraphobic cognitions predicted change in health-related QoL (all subscales of the RAND). Eight multiple linear regression analyses (method Enter) were conducted for this purpose: one for each of the RAND-36 subscale difference scores (i.e. the score at week 28 minus the score at week 0), with the slopes of the MI-AAL, ACQ, and RS entered as predictor variables. The results are presented in Table 3.

Table 3
Standardized Regression Coefficients of the Slope Factors of the RS, MI-AAL, and ACQ, and explained variance on the RAND-36 Subscale Difference Scores.

Dependent variables	Predictors: Slope factor			R^2
	MI-AAL	ACQ	RS	
RAND-36 subscales difference scores[a]				
General health perception	.10	.34	.62*	.27*
Physical functioning	–.28	.28	.02	.06*
Mental health	.10	–.12	.53*	.30*
Bodily pain	.45	–.00	.63*	.28*
Role limitations due to emotional problem	.37	–.16	.56*	.26*
Role limitations due to physical problem	.07	–.06	.45	.19*
Social functioning	.11	–.26	.23	.13*
Vitality	.07	–.15	.38	.18*

Note. The RS partly suppresses the relation between the RAND-36 subscale difference scores and the slope factors of MI-AAL and ACQ. Therefore, the presented standardized coefficients do not always have the same direction. Inspection of the correlations shows that the slope factor of MI-AAL and ACQ are correlated negatively and the slope factor of the RS is correlated positively with the RAND-36 subscale scores, as should be expected. RS = Remoralization Scale, MI-AAL = Mobility Inventory - Avoidance when Alone, and ACQ = Agoraphobic Cognition Questionnaire.

[a]The difference scores for the RAND-36 subscales were calculated to provide change over four-week intervals, so that change in the outcome is expressed over the same time interval as the predictors are. So difference scores for the RAND-36 subscales were calculated as follows: score at week 28 minus score at week 0 divided by 7 (i.e., number of four-week intervals).

*$p < .05$.

Change of remoralization significantly and strongly predicted change on the following RAND-36 subscale scores: general health perception, mental health, bodily pain, and role limitations due to emotional problem. Changes in the symptom measures did not significantly predict changes in the RAND-36 subscale scores. The amount of variance explained showed the three predictor variables together to explain a reasonable part of the variance in the RAND-36 subscales change scores. These results indicate, although tentative, that the measurement of RS has added value above and beyond the measurement of the MI-AAL and ACQ.

Discussion

The aim of the present study was to investigate the utility of remoralization as a supplemental outcome measure for the evaluation of treatment. We followed patients with PDA receiving a standard, indicated EST. As expected, the treatment was effective with respect to the symptoms: After 28 weeks, large decreases in agoraphobic avoidance and agoraphobic cognitions were observed. The effect sizes (Cohen's *d*s were 1.21 for MI-AAL and 1.19 for ACQ) were comparable with the effect sizes from meta-analyses on the treatment of panic disorder with agoraphobia (Cohen's *d*s varying from .91 to 1.25; see van Balkom et al., 1997; Oei et al., 1999). There were missing data for 7 participants (23 %), but no dropouts from treatment, save those who reported to have improved already. Our attrition rates, therefore, were lower than those commonly found in panic disorder patients treated with PCT or SSRI (see for instance: Keijsers, Kampman, & Hoogduin, 2001; Barlow, Gorman, Shear, & Woods, 2000). Meta-analyses generally suggest that that PCT and SSRIs are equally effective, and, although largely irrelevant for the research questions we were interested in, there were no differences in treatment efficacy between both treatments in our study also. With regard to the sensitivity of remoralization measurement change over time, we found a linear pattern of change: in every four week interval patients were more remoralized than in the interval before. The treatment was not only effective with respect to symptoms, but also with respect to remoralization. Its effect size (Cohen's *d* was 1.45) was even larger than those found for the two symptom measures.

When the changes over time in agoraphobic avoidance, agoraphobic cognitions and remoralization were compared, similar patterns were found. Despite the use of a homogeneous group of patients with one specific syndrome in a study with treatment aimed specifically at alleviation of the relevant symptoms, the course of remoralization showed a pattern similar to that for the course of the symptoms. This leads us to conclude that the symptoms of PDA patients change in a similar manner and at a similar pace as their remoralization and vice versa.

To determine if measuring remoralization has also a unique value, we examined whether remoralization of patients was more strongly related to health-related QoL (RAND-36 subscales) than changes in the symptoms of the patients did. This was indeed found to be the case for the following RAND-36 subscales: general health perception, mental health, bodily pain, and role limitations due to emotional problem. Contrary to these findings, agoraphobic avoidance and agoraphobic cognitions exhibited only a minimal unique relationship to the RAND-36 subscales. When patients experience remoralization during the course of treatment, they are also more likely to report a better overall feeling of health, less limitations on their work and daily activities, less bodily pain, and a better general health status. A high health-related QoL is, moreover, reported in the literature to be associated with less absenteeism from work (Hanebuth, Meinel, & Fischer, 2006), better social and global functioning, and better coping (de Vries & van Heck, 1997).

The present study is, to our knowledge, the first to actually investigate the utility of measuring remoralization as part of the evaluation of the outcome effects of disorder directed treatments. Furthermore, it is the first study that directly investigated the relationship between remoralization and symptom reduction, and the unique contribution of remoralization in relation to symptom reduction with regard to health related QoL. Although the present study is small and preliminary, it is innovative because it included patients with well-defined symptoms, the receipt of a standard indicated EST, and measurement of symptom reduction using instruments specifically selected for this purpose. In doing the latter, changes in remoralization and symptoms could more easily be distinguished. In the present research, moreover, we focused on the relationships between the patterns of change for remoralization and symptoms over time as opposed to their relationships at a single point in time. The present study thus overcomes some of the drawbacks on the research conducted on remoralization to date (e.g. Callahan, Swift, & Hynan, 2006; Grissom, Lyons, & Lutz, 2002; Hilsenroth, Ackerman, & Blagys, 2001; Lutz, Lowry, Kopta, Einstein, & Howard, 2001).

Our findings that remoralization and patient symptoms show a strongly correlated course for PDA patients receiving EST are not in concordance with the demoralization theory of Frank (1974) or the ideas of Howard and colleagues (1993) in which changes in remoralization are assumed to be distinguished from symptom reduction. The exact significance of the high correlations between symptom reduction and remoralization in the present study, is not completely clear, however. It is possible, for example, that symptom reduction enhances remoralization, remoralization leads to reduced symptomatology, or that the treatment offered simultaneously prompted remoralization and reduced symptomatology. Experimental study with treatment focused solely on the symptoms of a disorder versus treatment focused solely on remoralization should be undertaken to help unravel the relations between changes in

remoralization and the symptoms of a disorder as a consequence of psychotherapeutic treatment.

The present results nevertheless suggest that Frank and Howard were right about the fact that measuring remoralization as part of treatment outcome evaluation is valuable because remoralization, as being related to patients' estimates of being healthy in general, being mentally healthy, suffering no pain, and experiencing no daily limitations, contributes to a broader view of treatment enhancement — a view that includes more than just the assessment of symptom reduction. In sum and despite the preliminary nature of the present study, there is reason to believe that remoralization is a valuable measure to include in treatment efficacy research.

Chapter 4. The Distinction between Remoralization and Symptom Reduction

An Experimental Study

Vissers, W., Keijsers, G. P. J., Kampman, M., Hendriks, G., Rijnders, P., & Hutschemaekers, G. J. M. (2010). *The distinction between remoralization and symptom reduction: An experimental study*. Manuscript submitted for publication.

Abstract

Objective: Previous studies that tested the phase model of psychotherapy outcome (Howard, Lueger, Maling, & Martinovich, 1993) were not able to confirm the assumptions underlying the phase model. They do not appear to have been able to sufficiently differentiate between remoralization and symptom reduction (i.e., the outcomes of the first two phases). Whether or not remoralization and symptom reduction can be distinguished was therefore investigated experimentally in the present study. **Method:** Patients suffering from panic disorder with agoraphobia (N = 78; mean age: 36.99 yrs [SD = 12.5]; 28 male) were randomly assigned to a 4-week remoralization treatment (RT), which was strictly focused on remoralization, a 4-week exposure treatment (ET), which was strictly focused on symptoms, or a 4-week waiting list. The Subjective Well-being Scale (Howard et al.) was used to measure pre/post remoralization change and the Panic-Agoraphobia Scale (Bandalow, 1995) was used to measure pre/post panic symptoms. **Results:** Significant improvement was found for the intended effects of the treatments. RT increased remoralization significantly (ES = 0.70) and ET reduced symptoms significantly (ES = 0.72). In addition, unintended effects of the treatments were found as well. RT significantly affected symptom reduction (ES = 0.55) and ET significantly affected remoralization (ES = 0.76). **Conclusions:** It is unlikely, at least for patients suffering from panic disorder with agoraphobia, that remoralization and symptom reduction can be distinguished empirically. This difficulty may explain why earlier studies on the phase model have not been able to confirm the assumptions underlying the phase model.

Introduction

The process of change during psychotherapy can be viewed as the cornerstone of clinical practice and meta-theories as the renowned *phase model of psychotherapy outcome* (phase model; Howard, Lueger, Malin, & Martinovich, 1993), in which the process of change in psychotherapy are unfolded, are of central interest. In this model, psychotherapy is assumed to progress in a stepwise manner with each phase depending upon a previous phase and each phase representing a different domain of psychotherapeutic change. The first phase in the model draws upon the demoralization theory of Frank and Frank (1991) and is therefore referred to as the *remoralization phase*. During this phase, patients overcome their state of demoralization, regain hope that their problems can be resolved, and experience an increased sense of subjective well-being. The second phase addresses the symptoms of the patient and is referred to as the *remediation phase*. Coping is facilitated and improved in order to bring about symptom relief. The third phase is the *rehabilitation phase*, which is "focused on the unlearning of troublesome, maladaptive, longstanding patterns and the establishment of new ways of dealing with various aspects of self and life" (Howard et al., p. 680).

Given the simplicity and transparency of the phase model in addition to its detailed description of the phases, the model proved attractive and theoretically valuable for clinicians. Clinicians recognize the phases for all kind of patients from their own professional practices (Joyce, Ogrodniczuk, Piper, & McCallum, 2002). But how well has the phase model been validated empirically? At first sight, the model seems empirically validated because six early studies—including four by the research team of Howard—have confirmed the assumptions underlying the phase model (Barkham, Rees, Stiles, Shapiro, Hardy, & Reynolds, 1996; Hilsenroth, Ackerman, & Blagys, 2001; Howard et al., 1993; Kopta, Howard, Lowry, & Beutler, 1994; Lutz, Lowry, Kopta, Einstein, & Howard, 2001; Martinovich, 1998). At the same time, doubts can be raised about the empirical validation of the phase model because three later studies, (Callahan, Swift, & Hynan, 2006; Holloway, 2004; Joyce et al., 2002) did not yield further confirmation for the assumptions underlying the phase model.

Let us scrutinize the assumptions of the phase model. In the phase model, it is assumed that patients in psychotherapy improve on a number of outcome measures in a systematic manner but not at the same time. According to Howard et al. (1993), psychotherapeutic change is not random but follows a customary sequence. Demoralization decreases within the first few sessions. After the establishment of remoralization, the patient moves into the phase of remediation in which actual symptom reduction takes place. Most patients terminate treatment after this phase. Those patients who continue with treatment progress to the last phase: rehabilitation. The assumption of a temporal relation between the different phases of psychothera-

peutic change is thus the first basic assumption underlying the phase model of psychotherapy outcome.

The second basic assumption underlying the phase model is the so-called conditional relation of the phases. Significant improvement in the preceding phase is a necessary condition for the occurrence of improvement in the next phase. In other words, remoralization must take place *before* symptom reduction can occur. And symptom reduction must take place *before* rehabilitation can occur.

In the following, we will consider the empirical evidence for the two basic assumptions underlying the phase model. We will focus on the first two phases of the model because only a minority of patients receiving psychotherapeutic treatment are expected to stay in therapy long enough to enter the third phase (Howard et al., 1993).

Assumption 1: The temporal relation of the phases

In a total of five studies (Barkham et al., 1996; Hilsenroth et al., 2001; Howard et al., 1993; Kopta et al., 1994; Lutz et al., 2001), the amount of change in remoralization and symptom reduction for patients receiving treatment was dichotomized as "improved" or "non-improved" in order to examine the temporal sequence of the first two phases in the phase model. The authors compared the percentages of patients who had improved on remoralization (referring to the first phase), and on symptom reduction (referring to the second phase) at different points across the period of treatment, which could range from pre-treatment to an average of 16 sessions (for Kopta et al. and Lutz et al. to as many as 52 sessions). The results showed a larger percentage of the patients to improve for remoralization than for symptom reduction. This finding led the authors of the five studies to conclude that remoralization of patients in psychotherapy occurs faster than symptom reduction and that psychotherapeutic change thus occurs in the stepwise manner as proposed by the phase model.

This conclusion is open to debate, however. Whether or not symptom reduction (i.e., remediation) actually constitutes a *later* phase of change than remoralization cannot be deduced on the basis of the data analyzed in these studies. This is because the ratio of patients improved on remoralization to patients improved on symptom reduction did not change over time; that is, the ratio was *stable* across the different points in time. There was no difference for the earlier versus later sessions, although this might be expected on the basis of the phase model. Inspection of the figures depicting the percentages of improved patients for remoralization and symptom reduction over time (Barkham et al., 1996; Howard et al., 1993; Kopta et al., 1994), moreover, shows virtually no different growth line in either measure. It is thus not clear that one measure actually changes *earlier* than the other or that the measures start to accelerate at different points in time. In the figures of Howard et al. and Kopta et al., the change in remoralization can be seen to be largest in the first few treatment sessions, but this can also be seen to be the case for symptom reduction as well. Remoralization does not

accelerate earlier than symptom reduction. The reported data, thus, do not provide conclusive evidence for the first assumption of the phase model, the temporal relation of the phases. The unpublished findings of Martinovich (1998) may point in a different direction, but they could not be retrieved for inspection.

Moreover, the five studies taken to provide support for the temporal sequence of the phase model (Barkham et al., 1996; Hilsenroth et al., 2001; Howard et al., 1993; Kopta et al., 1994; Lutz et al., 2001) suffer from several methodological problems. The use of dichotomized data to indicate improvement is likely to have resulted in a significant loss of information (Cohen, 1990). An increase in the likelihood of erroneous conclusions may occur as a result of this loss of information. General symptom checklists were used to measure symptom reduction (Hilsenroth et al.; Howard et al.; Kopta et al.; Lutz et al.), but these instruments are designed to measure general feelings of discomfort as opposed to specific symptoms. These instruments are less suited to distinguish the remediation phase (with reduction of symptoms) from the remoralization phase (with increase of remoralization). In addition, the studies used heterogeneous or unclear patient samples, and either the type of treatment was unspecified or the treatment was aimed at such a wide array of syndromes and problems that it is unclear what the observed effects of treatment should be ascribed to.

As opposed to the other studies Barkham et al. (1996) studied a uniform patient population using a symptom-specific instrument. Unfortunately, Barham et al. used the same instrument to measure both, symptom reduction and remoralization, which makes it difficult to pinpoint those changes that belong to remoralization and those changes that belong to remediation. Both Joyce et al. (2002) and Holloway (2004) have failed to find empirical proof for the assumption of the temporal relation of the phases of the phase model. Drawing upon observational data, these studies did not suffer from a potential loss of information due to the dichotomization of data. However, proper pre-treatment assessments did not take place. First assessment of Joyce et al. took place after session four; first assessment of Holloway took place after session one or two. Note that important changes in remoralization might have already occurred prior to initial assessment. A clear conclusion regarding the assumption of a temporal relation of the phases cannot, thus, be drawn as yet.

Assumption 2: The conditional relation of the phases

Three studies were particularly aimed at examining the assumption that improvement of remoralization is a condition for the remediation phase (Callahan et al., 2006; Joyce at al., 2002; Howard et al., 1993). Crosstabs and chi-square analyses were undertaken to compare the numbers of improved versus non-improved patients. That is, how many patients showed improved remoralization in combination with non-improved symptom reduction, versus non-improved remoralization in combination with improved symptom reduction at particular points in time? If the phases are conditionally related, the first

should show greater numbers than the latter. However, only Howard et al. has detected such a distribution. Callahan et al. and Joyce et al. did not find the expected distribution at most of the points that they analyzed.

Joyce et al. (2002) also investigated the pre-condition assumption by examining the two sequences, remoralization preceding symptom reduction, and symptom reduction preceding remoralization. Both sequences were found to occur, and no one sequence occurred more often than the other.

The—at best—ambiguous evidence regarding the conditional relation of the phases appears to stem at least in part from the previously discussed concerns related to dichotomization of data, the use of general symptom checklists, unspecified patient samples, unspecified or general treatments, and—in the case of Joyce et al. (2002)—a lack of proper pre-treatment assessment. Therefore we could not draw any definite conclusions about the pre-condition assumption.

New studies

In a recent study of the added value of measuring remoralization in addition to symptom reduction in outcome research, patients suffering from panic disorder and agoraphobia were given indicated, empirically supported treatments (Vissers, Keijsers, van der Veld, Hendriks, & Hutschemaekers, 2010). The treatments were well-defined, symptom-directed, and undertaken with a homogeneous sample of patients. To assess remoralization and symptoms over time, separate and specific instruments were used. This means that this study should have been able to better distinguish changes in remoralization from changes in remediation than in previous studies. Both strong remoralization and strong symptom effects were found. Contrary to the expectations, however, the courses of remoralization and symptom reduction were highly correlated. That is, the timing and degree of change for the remoralization and remediation phases of psychotherapeutic change overlapped considerably. These findings together with the findings of the previously discussed studies can be explained in two manners. First, it is possible that the naturalistic study designs allowed for too much noise and that this noise masked any underlying differences between the remoralization and remediation phases of psychotherapeutic change. It is, alternatively, possible that the supposition underlying Howard's phase model (and underlying the two described assumptions) that remoralization and symptom reduction are two distinguishable processes, simply does not hold.

Greater empirical insight into the relations between remoralization and symptom reduction should be gathered before further research on the phase model is conducted. In the present study, we therefore compared the effects of treatment focused solely on remoralization versus treatment focused solely on the symptoms of the disorder. This experimental research design was adopted in order to maximize the likelihood of distinguishing the remoralization and remediation phases (i.e., the differences predicted by

the phase model). It was reasoned that, if remoralization and symptom reduction can really be distinguished, as the phase model proposes, the treatment aimed at remoralization should not lead to clear symptom reduction; and conversely, the treatment aimed at remediation should not lead to clear increases in remoralization.

Method

Design

In an experimental study, patients with panic disorder with agoraphobia (PDA) were randomly allocated to one of three conditions: brief remoralization treatment (RT), brief exposure treatment (ET), or a four-week waiting list (WL). Time 1 measurement (T1) took place prior to randomization. Time 2 measurement (T2) took place 5 weeks later. This meant that the patients in the treatment conditions had completed their fourth and final session.

A total of 30 patients per condition was judged to be required for a statistical power of 80%, an $\alpha < .05$, and comparison of the treatment conditions with WL with an estimated Effect Size (*ES*) of 0.80 for the reduction of panic symptoms and 0.70 for remoralization (Cohen, 1992). De Beurs, van Balkom, Lange, Koele, and van Dyck (1995) reported an *ES* of 1.32 for a six-session exposure-in-vivo treatment of panic disorder patients. We thus presumed an *ES* of .80 to be feasible within the context of the present study (i.e., four as opposed to six sessions of exposure in-vivo). Remoralization effects with an *ES* of 0.38 were found for students receiving a single session of relaxation treatment (Ermers, 2005). In the current study, it was thus expected that these remoralization effects could be doubled (i.e. *ES* of 0.70) because we included patients as opposed to students (patients are expected to be more demoralized) and because sharp increases in remoralization following the first four sessions of treatment have been previously reported (Howard et al., 1993; Lutz et al., 2001).

The study was approved by the Dutch Central Committee for Human Related Research (i.e., ethical research committee).

Participants and procedure

A total of 150 patients from an outpatient clinic, the Pro Persona Centre for Anxiety Disorders *Overwaal*, was invited at intake to participate in the present study when they met the inclusion criteria. The intake at the clinic entailed two sessions. The Mini International Neuropsychiatric Interview (Lecrubier et al., 1997) was administered by independent assessors in order to determine the DSM-IV classification for the patients' disorders. The inclusion and exclusion criteria for the present study were in line with criteria of efficacy studies on the treatment of panic disorder with agoraphobia (Westen

& Morrison, 2001) and were as follows: a present DSM-IV classification of PDA and an age of 18 to 65 years. The exclusion criteria were: receipt of other psychological treatment, meeting the DSM-IV criteria for a severe mood disorder with or without psychotic features, schizophrenia, mental retardation, suicidal ideation, or alcohol or psychoactive substance abuse or dependence.

When judged to be eligible for inclusion in the study, the patients were given written information about the study and asked to provide permission to be contacted by phone. Those patients who agreed to be contacted were called within one week after the second intake session; the study was explained in greater detail; and the patients were invited to participate in the present study while awaiting for their formal treatment to begin. The waiting time from intake to initiation of outpatient treatment was an average of 5.5 months at the time of the start of the present study.

A total of 95 patients agreed to participate. At T1, the patients were asked to provide their written informed consent. They were then administered three self-report scales to determine their state of remoralization and symptoms (see Measures). At the end of T1, the patients were randomly assigned to one of the conditions (i.e., a three-arm parallel trial design was followed). Randomization was carried out for successive blocks of 15 subjects (5 ET, 5 RT and 5 WL) in order to arrive at equal numbers of patients per condition. Additionally, stratification was adopted for the use of anti-depressant medication.

One week after T1, weekly treatment sessions were initiated with the patients in the two treatment conditions. At the end of the fourth and final treatment session, the patients were asked by an independent assessor to again complete the three self-report scales (T2). The patients in the WL condition were invited to the clinic to again complete the three self-report scales 5 weeks (T2) after initial assessment.

Seventy-eight patients completed the study and the demographic characteristics of the population who completed the study are summarized in Table 1. In addition to a DSM-IV axis I disorder, three of the patients also had a co-morbid DSM-IV axis II disorder: one in RT and two in WL. Of the 34 patients taking antidepressants, 29 had SSRIs and 5 tricyclic or other antidepressants. Of the 30 patients taking benzo-diazepines, 11 were taking an antidepressant as well. All of the patients taking psycho-tropic medication were asked to adhere to the set daily dosage during the course of the study.

Treatment conditions

General aspects. Both treatment conditions involved four weekly treatment sessions with a duration of 45 minutes each, that were described in detail in a manual. After each session, homework was assigned. And each treatment condition was piloted on five PDA patients.

All sessions were audiotaped for supervision purposes and to check for treatment integrity. With regard to the latter, 15% of the audiotaped sessions were selected at random. A graduate teaching assistant, who was naive with regard to the content and goals of the present study, listened to the audiotapes and used a checklist to rate whether or not he recognized the main features of the two brief treatments. This resulted in a 100 % correct classification (i.e. either RT or ET) for all of the selected sessions.

Brief exposure treatment (ET). Development of agoraphobia is seen as an aggravation and complication of panic disorder and often considered the most impairing aspect of PDA (Barlow, 1988; de Beurs & Widenfelt, 2004). For this reason, exposure in-vivo, directly aimed at the agoraphobia, was decided upon as the course of treatment for the symptoms of PDA in the present study. The exposure in-vivo component is one of the four components of the repeatedly tested and clearly effective Panic Control Treatment (PCT) of Craske and Barlow (1993; van Balkom, Bakker, Spinhoven, Blaauw, Smeenk, & Ruesink, 1997). This component has been shown to clearly contribute to the effectiveness of PCT (de Beurs et al., 1995).

In the first ET session, psycho-education about anxiety and avoidance behavior was undertaken and, together with the therapist, the patient constructed a hierarchy of a large variety of relevant phobic situations. The patient was then given the assignment to expose him of herself, guided by the hierarchy of phobic situations, to complete for the second, third, and fourth treatment sessions. The exposure assignments were evaluated and discussed during the treatment sessions. In the ET sessions, no problems other than the patient's agoraphobic avoidance were discussed. If a patient started to talk about other problem areas, the therapist politely brought the focus back to the exposure assignment and hierarchy. The therapist took a supportive, coaching stance and encouraged the patients to perform the exposure assignments.

Brief remoralization treatment (RT). A four-session remoralization treatment was derived from the work of Rijnders (2004) who developed a brief therapy aimed at remoralization of patients. Rijnders' brief therapy, which involves seven or eight sessions, is strongly based upon Frank's demoralization theory and contains elements of strategic psychotherapy, behavior therapy, and solution-focused therapy. Hakkaart-van Roijen, van Straten, Rutten, & Donker (2006) showed this therapy to be just as effective as cognitive behavior therapy.

In the RT condition, attention was not paid to specific PDA symptoms but, rather to the explanation of the problems experienced by the patient in terms of failed problem solving and inadequate coping strategies. The RT was aimed at identification of the patient's competencies and stimulation of these competencies via step-by-step problem solving. The goal was not to reduce symptoms but to elicit perspective and hope. In the first session, a hypothesis about the relationship between the patient's problems and his or her circumstances was sought. As homework assignment, the patient was then instructed to think and talk about the circumstances that appear to make

his or her usual problem-solving strategies fail. In the second session, the patient's hypothesis was extended to include his or her personal coping style: The patient's problems can be seen as a result of his or her particular circumstances and specific manner of coping. In the remainder of the sessions, behavior-change experiments were proposed, discussed, and carried out by the patient. Although the therapists in the RT condition had to acknowledge the suffering of the patients at times, they refrained from intervening to directly reduce the incidence of symptoms.

Therapists and assessors

Therapists were graduate students in clinical psychology who were fulfilling their practical internship at the Pro Persona Centre for Anxiety Disorders *Overwaal* and at an university outpatient clinic. All of the therapists received a two-day training on ET and a two-day training on RT. Throughout the study, the therapists were supervised on a weekly basis by two experienced clinical psychologists: one who is specialized in exposure treatment and one who is specialized in remoralization treatment, to ensure that the therapists adhered to the treatment manuals. Audiotaped-recordings of the sessions were used in these supervision sessions.

The assessors on the T1 and T2 measurement occasions were also graduate students in clinical psychology who were fulfilling their practical or research internship, different than the therapists, and blind to the treatment conditions for the patients being assessed.

Measures

Remoralization was measured using two instruments. The Subjective Well-being Scale (SWS; Grissom, Lyons, & Lutz, 2002) is a 3-item adaptation of the original instrument used by Howard et al. (1993) to assess remoralization. The three items constituting the SWS are responded to using Likert scales with a range of 1 to 4, 1 to 5, and 1 to 6, respectively. The SWS has good internal consistency and validity. High scores indicate strong remoralization. The SWS is treated as the primary measure of remoralization in the present study because it corresponds most to the measures used in the original studies of the phase model. However, the usefulness of the SWS is unknown for cases of PDA. The Remoralization Scale (RS; Vissers, Keijsers, van der Veld, de Jong, & Hutschemaekers, in press), a measure of remoralization that has been recently developed and tested on a population of patients with PDA, was therefore included as a secondary measure of remoralization in the present study. The RS assesses changes in remoralization as a result of treatment. The RS is a psychometrically sound, self-report instrument that measures growth of hope, subjective well-being, and sense of mastery. Patients are required to rate on a four-point scale the extent to which they agree with

each of 12 statements, with higher RS scores indicating greater remoralization. Internal consistency and test-retest reliability are excellent (Vissers et al.).

The Panic and Agoraphobia Scale (PAS; Bandelow, 1995) was used to measure symptoms of panic and agoraphobia. The PAS is a psychometrically sound instrument that requires respondents to respond to 13 items using a four-point Likert scale. The incidence of panic attacks, avoidance behavior, anticipatory anxiety, disability, and worries about health is assessed. A higher PAS score indicates more symptoms of panic and agoraphobia.

Data analyses

Analyses were conducted on the data for completers (ET, n = 28; RT, n = 26; WL, n = 24). We decided on this approach as opposed to an intention-to-treat analysis because the present study was *not* concerned with demonstration of treatment efficacy. For the main analyses of the data change scores (i.e., T1 minus T2) were calculated. Each change score was entered separately into a one-way ANCOVA — one for SWS, one for RS and one for PAS — with three conditions (ET, RT, WL) and the T1 scores as the covariate. After checking for a main effect of condition, planned contrasts were undertaken (Maxwell & Delaney 2004): The change scores for ET were compared to those for WL, and the change scores for RT were compared to those for WL. Bonferroni adjustments were made to control for the inclusion of three dependent variables. An alpha of .05 divided by the 3 thus resulted in an alpha level of .017.

There were no missing data for the primary measures (SWS and PAS). Due to a logistic failure, 17 % of the data of the secondary remoralization measure was missing completely at random. For this reason, we used multiple imputation (Little & Rubin, 1990; Rubin, 1987). That is, we imputed 10 data sets and averaged predictions and *SE*s for uncertainty due to imputation.

Results

Attrition

As can be seen from Figure 1, 150 patients were found to be potentially eligible for inclusion in the study and 126 met the inclusion criteria. A total of 95 agreed to participate and were randomly assigned to one of three conditions at T1. Immediately thereafter, 4 patients dropped out. An additional 13 patients dropped out just before T2. When the scores on the two measures of remoralization and the scores on the measure of symptoms at T1 were compared for the dropouts versus the completers, no significant differences were found.

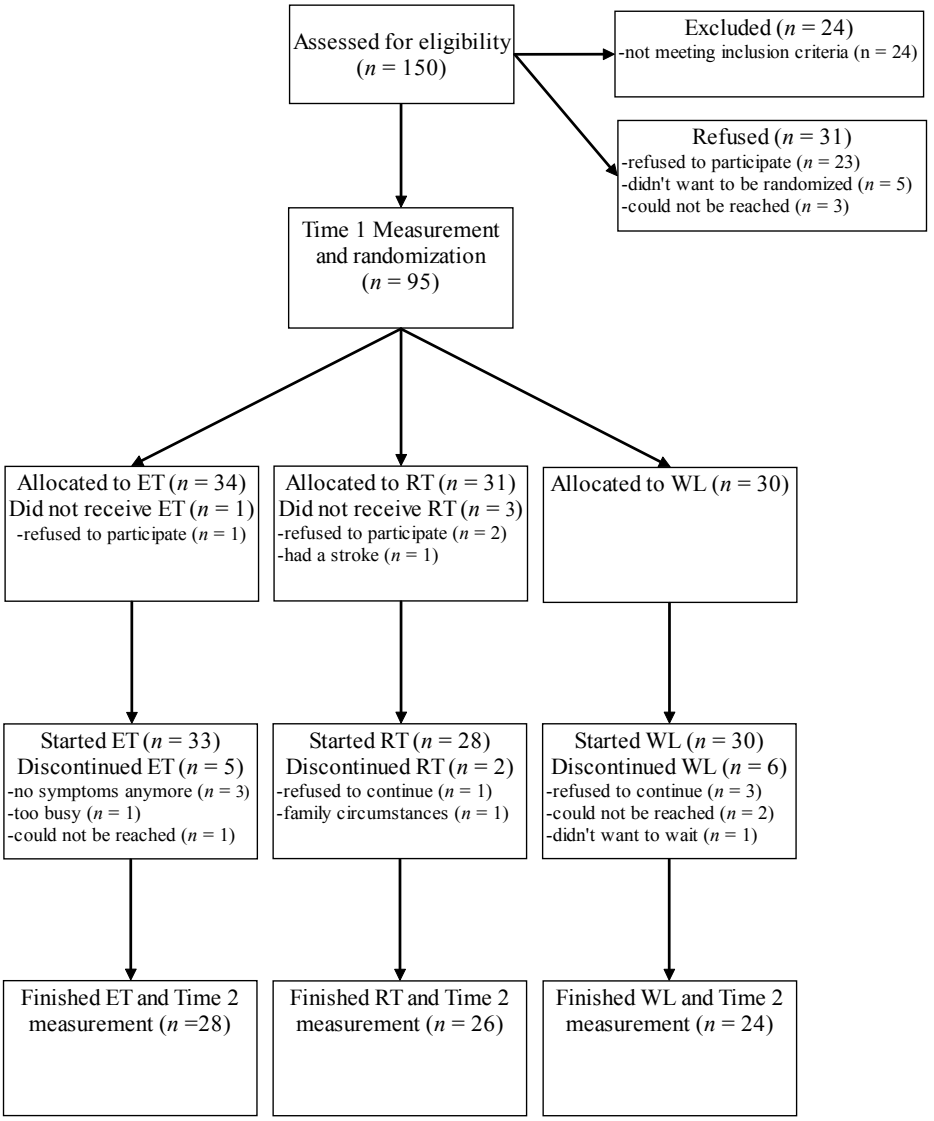

Figure 1. Overview of patient participation and dropout. ET = brief exposure treatment, RT = brief remoralization treatment, WL = waiting list control.

The study was conducted between December 2005 and November 2008. While the required sample sizes had yet to be obtained by November 2008, the average waiting time for the outpatient clinic had dropped to less than five weeks, which rendered inclusion in our study impossible.

Preliminary analyses

The ET, RT, and WL groups did not differ with regard to any of the demographic characteristics (see Table 1).

Table 1
Demographic and Clinical Characteristics of Patients.

Variable	ET $n = 28$	RT $n = 26$	WL $n = 24$	Test value (*df*)	*p*
Age, years (*SD*)	33.4 (11.1)	37.8 (13.1)	40.3 (13.6)	F (2,75) = 2.00	.14
Male, % (*n*)	35.7 (10)	23.1 (6)	50.0 (12)	χ^2 (2) = 3.93	.14
Education, years (*SD*)	12.3 (2.2)	11.7 (2.7)	11.8 (3.1)	F (2,73) = 0.48	.62
Marital or living status:				χ^2 (4) = 3.56	.47
Never married, % (*n*)	46.4 (13)	38.5 (10)	34.8 (8)		
Divorced, % (*n*)	00.0 (0)	11.5 (3)	08.7 (2)		
Married or living with partner, % (*n*)	53.6 (15)	50.0 (13)	56.5 (13)		
Employed, % (*n*)	66.7 (16)	54.2 (13)	45.5 (10)	χ^2 (2) = 2.13	.35
Panic symptoms, years (*SD*)	05.0 (6.2)	05.8 (8.0)	07.3 (10.5)	F (2,71) = 0.47	.63
Co-morbidity, % (*n*)	64.3 (18)	42.3 (11)	37.5 (9)	χ^2 (2) = 4.35	.11
Sort co-morbidity:					
Depression, % (*n*)	21.4 (6)	11.5 (3)	08.3 (2)		
Hypochondria, % (*n*)	17.9 (5)	11.5 (3)	04.2 (1)		
Social phobia, % (*n*)	14.3 (4)	07.7. (2)	12.5 (3)		
GAD, % (*n*)	10.7 (3)	07.7. (2)	12.5 (3)		
Specific phobia, % (*n*)	14.3 (4)	03.8 (1)	08.3 (2)		
OCD, % (*n*)	10.7 (3)	03.8 (1)	04.2 (1)		
Other, % (*n*)	07.2 (2)	11.5 (3)	00.0 (0)		
Antidepressant, % (*n*)	42.9 (12)	46.2 (12)	41.7 (10)	χ^2 (2) = 0.11	.95
Benzodiazepine, % (*n*)	28.6 (8)	42.3 (11)	45.8 (11)	χ^2 (2) = 1.87	.39

Note. ET = brief exposure treatment, RT = brief remoralization treatment, WL = waiting list control. GAD = generalized anxiety disorder, OCD = obsessive compulsive disorder, AD = adjustment disorder.

In Table 2, the baseline and post-treatment scores on the three outcome measures and the estimated effect sizes for the three groups are presented. After checking for the basic assumptions of multivariate normality and homogeneity of variance, we tested whether the three groups differed from baseline on the SWS, RS, and PAS. The overall MANOVA did not yield a significant Wilks' Lambda, F (6, 148) = 1.59, p = .15.

Table 2

Descriptive Statistics for Outcome Measures at Times 1 and 2.

Measure/condition (n)	M_{Time1} (SD)	M_{Time2} (SD)	ES[a] (95 % CI)
Subjective Well-being Scale			
ET (28)	3.10 (0.58)	3.58 (0.66)	0.76 (0.22, 1.30)
RT (26)	2.76 (0.66)	3.30 (0.85)	0.70 (0.14, 1.26)
WL (24)	2.69 (0.75)	2.79 (0.92)	0.12 (–0.68, 0.45)
Remoralization Scale			
ET (28)	2.64 (0.43)	2.85 (0.51)	0.47 (0.06, 1.00)
RT (26)	2.56 (0.52)	2.90 (0.38)	0.74 (0.17, 1.30)
WL (24)	2.44 (0.54)	2.47 (0.61)	0.05 (–0.62, 0.51)
Panic and Agoraphobia Scale			
ET (28)	1.71 (0.71)	1.20 (0.69)	0.72 (0.18, 1.26)
RT (26)	1.68 (0.79)	1.23 (0.83)	0.55 (0.01, 1.10)
WL (24)	2.00 (0.86)	1.97 (1.03)	0.03 (–0.53, 0.60)

Note. ET = brief exposure treatment, RT = brief remoralization treatment, WL = waiting list control, CI = Confidence Interval.

[a]Estimated effect size was calculated as Hedges' g $(M1 - M2)/SD_{pooled}$; $SD_{pooled} = \sqrt{([(n1 - 1)SD1^2 + (n2 - 1)SD2^2]/n1 + n2 - 2)}$.

Intended treatment effects

After checking that the basic assumptions of normality, homogeneity of variance, and homogeneity of regression were met, our main ANCOVA's were conducted. The covariate SWS at T1 did not relate significantly to the change scores for SWS, F(1, 74) = 3.40, p = .07. A significant effect of condition on the SWS change scores was, however, apparent, F(2, 74) = 4.60, p = .013. Planned contrasts showed RT to elicit significantly greater increases in SWS than WL (i.e., no treatment), t(74) = 2.63 , p = .010. The covariate RS at T1 related significantly to the change scores for RS, F(1,74) = 7.04, p = .013. There was a significant effect of condition on the RS change scores as well, F(2, 74) = 7.67, p = .001. Planned contrasts showed RT to elicit significantly greater increases in RS than WL, t(74) = 3.82 , p = .001. The covariate PAS at T1 was significantly related to the change scores for PAS, F(1, 74) = 7.99, p = .006. A significant effect of condition on the PAS change scores was found, F(2, 74) = 5.71, p = .005. Planned contrasts showed ET to elicit significantly greater decreases in PAS than

WL, $t(74) = 3.10$, $p = .003$. Both treatments thus realized those effects that they were intended on.

Unintended treatment effects

Recall that the main aim of the current research was to investigate whether RT *also* resulted in symptom reduction and whether ET resulted in remoralization as well. Given that the progress of a patient with respect to remoralization and symptom reduction should be distinct according to the phase model (Howard et al., 1993), it was hypothesized that ET should *not* lead to significant increases in SWS or RS and that RT should *not* lead to significant decreases in PAS. Planned contrasts showed ET to elicit significantly greater increases in SWS than WL, $t(74) = 2.66$, $p = .010$, and marginally greater increases in RS than WL, $t(74) = 2.22$, $p = .019$. Planned contrasts showed RT to elicit significantly greater decreases in PAS than WL, $t(74) = 2.79$, $p = .007$.

In other words, both treatments — which were aimed only at one effect — elicited changes on the measure of the unintended effect as well.

Discussion

The aim of the present study was to investigate whether the treatment effects of remoralization could be distinguished from the treatment effects of symptom reduction. An experimental research design in which the effects of treatment for PDA on patients who were randomly assigned to one of three conditions was adopted. The conditions were brief exposure treatment (ET), designed to strictly reduce symptoms of patients, brief remoralization treatment (RT), designed strictly to remoralize patients, or a waiting list (WL) control. The research design and decisions made with respect to the selection of outcome measures, treatment approach, and patient sample were all aimed at maximizing the a priori chances of finding distinct effects for remoralization and symptom reduction.

As expected, both of the treatment conditions elicited the intended outcome effects respectively. After only four sessions, ET significantly reduced symptoms of panic and agoraphobia ($ES = 0.72$) and RT significantly increased remoralization ($ES = 0.70$ for SWS; $ES = 0.74$ for RS). These effects were moderately large and comparable to those reported for the reduction of panic symptoms (de Beurs et al., 1995) and increase of remoralization (Ermers, 2005) with (very) brief mono-treatment.

We were particularly interested in the possibly *unintended* effects of the different brief treatments. Our reasoning was as follows. If both treatments produce not only intended effects but also unintended effects, then it is difficult to maintain that remoralization and symptom reduction can be distinguished. That is, our data can show either the two outcomes to be distinguishable or to co-occur. The latter suggests that one

effect may prompt the other to occur and vice versa. In the present study, both brief treatments showed significant unintended outcome effects: RT produced not only remoralization but also a reduction of symptoms (*ES* = 0.55); ET produced not only symptom reduction but also increased remoralization (*ES* = 0.76 for SWS; *ES* = 0.47 for RS).

The attrition rate of 18% from T1 (i.e., the moment of allocation) to T2 (i.e., post-treatment measurement) is comparable or lower than the rates commonly reported for panic disorder patients (see, for instance, Barlow, Gorman, Shear, & Woods, 2000; Keijsers, Kampman, & Hoogduin, 2001). Once treatment started, the dropout rates were not equal across the three conditions. More patients dropped out of the WL and ET conditions than the RT condition (6, 5, and 2, respectively). Speculation that RT may be easier for the patient to continue than no treatment or ET is tentative, considering the small number of patients and because three out of six patients who dropped out from ET mentioned they had no symptoms left as reason for their drop out.

Although the present study is small and the present findings must therefore be considered preliminary, it is innovative because it definitely was not aimed at demonstrating treatment efficacy of the applied treatments, but it was designed instead to experimentally investigate whether two treatment effects could be manipulated separately. The treatment effects were evaluated according to the sophisticated standards for randomized clinical trials. The brief treatments that were intentionally designed to be brief, specific and strictly manualized, produced the pre/post changes they were designed for. The brief treatments were designed along the lines of treatment-analogous laboratory manipulations, which means that the methodological sophistication of laboratory experiments was combined with the ecological validity of undertaking real treatment with real patients. One can object that the design had little ecological validity but, in our opinion, such a treatment-analogous laboratory design was necessary to maximize the a priori change to unravel the relation between remoralization and symptom reduction.

Despite our research design, it is *still* possible that the ET may have been inadvertently aimed at remoralization of the patient or, conversely, the RT may have inadvertently urged the patient to deal with his or her agoraphobic avoidance. In addition, the fact that the therapists were trained to administer both types of treatment might have blurred the boundaries between the two forms of treatment provided. However, a correct treatment classification of 100% in the integrity analyses points in the opposite direction. As a significant distinction between remoralization and symptom reduction using a well-controlled research design cannot be demonstrated, the question can be raised whether this distinction, if it exists, is of relevance for clinical practice.

With the use of a specific patient population (i.e., patients with PDA), we were able to investigate symptom reduction specifically and validly. This approach also methodologically enlarged the a priori chances of detecting a distinction between

remoralization and symptom reduction. However, the use of this patient population, in hindsight, may have masked an actual distinction between remoralization and symptom reduction. Patients with PDA are known to improve quite well with psychotherapy (e.g. Oei, Llamas, & Devilly, 1999; van Balkom et al., 1997). In the present research, relatively large effects for only four treatment sessions were indeed the case. For patient populations with more chronic syndromes, such as schizophrenia, the distinction between remoralization and symptom reduction may be more clear and symptom reduction may indeed be less likely to occur than remoralization in such cases (Shrivastava, Johnston, M., Shah, & Bureau, 2010; Strauss, 1994). However, the phase model is expected to apply to all kinds of patients and particularly patients who may benefit from the remediation phase (Howard et al., 1993); patients with PDA, for example.

The original studies of the phase model (Barkham et al., 1996; Callahan et al., 2006, Hilsenroth, 2001; Howard et al., 1993; Holloway, 2004, Joyce, et al., 2002; Kopta et al., 1994; Lutz et al., 2001) did not provide a conclusive answer for the question of whether the assumptions of temporal and conditional relation of the first two phases of the phase model are empirically valid. Based on the present findings, we are inclined to think that these studies also failed to distinguish between remoralization and symptom reduction during the process of psychotherapeutic change.

Frank (1974) and Howard et al. (1993) were right in their assumption that successful psychotherapy produces multiple effects: symptom reduction, on the one hand, and remoralization, on the other hand. In line with the results of previous studies, however, we were not able to empirically distinguish these two outcome effects from each other. While our study was not designed to test the assumptions about the temporal and conditional relations between the phases of psychotherapeutic change, our results do not point in the direction of confirmation of these assumptions.

Chapter 5. Treatment Implication of the Phase Model of Psychotherapy Outcome

An Experimental Study

Vissers, W., Keijsers, G. P. J., Kampman, M., Rijnders, P., & Hutschemaekers, G. J. M. (2010). *Treatment Implication of the Phase Model of Psychotherapy Outcome: An Experimental Study*. Manuscript submitted for publication

Abstract

The phase model (Howard, Lueger, Maling, & Martinovich, 1993) presumes that different topics should be addressed during different phases of therapy. Studies testing this model, however, have not tested this presumption. The present study experimentally investigated whether a treatment that focused on remoralization first and on symptom reduction second, in line with the phase model, was more effective than a treatment that focused on symptom reduction first and on remoralization second. Patients suffering from panic disorder with agoraphobia (N = 72) were randomly assigned to one of the 8-session treatments or a waiting list. The two treatments proved equally effective for remoralization and symptom reduction. The treatment in line with the phase model was no more effective than the other treatment.

Introduction

The process of change during psychotherapy can be viewed as the cornerstone of clinical practice and such meta-theories as the renowned *phase model of psychotherapy outcome* (phase model; Howard, Lueger, Malin, & Martinovich, 1993), in which the process of change in psychotherapy is described, are of central interest. In the phase model psychotherapy is assumed to progress in a stepwise manner with each phase depending upon a previous phase and each phase representing a different domain of psychotherapeutic change. The first phase in the model draws upon the demoralization theory of Frank and Frank (1991) and is therefore referred to as the *remoralization phase*. During this phase, patients overcome their state of demoralization, regain hope that their problems can be resolved, and experience an increased sense of subjective well-being. The second phase addresses the symptoms of the patient and is referred to as the *remediation phase*. Coping is facilitated and improved in order to bring about symptom relief. The third phase is the *rehabilitation phase*, which is "focused on the unlearning of troublesome, maladaptive, longstanding patterns and the establishment of new ways of dealing with various aspects of self and life" (Howard et al., p. 680).

Let us scrutinize the basic assumptions of the phase model. In the phase model, it is assumed that patients in psychotherapy improve on a number of outcome measures in a systematic manner but not at the same time. According to Howard et al. (1993), psychotherapeutic change is not random but follows a customary sequence. Demoralization decreases within the first few sessions. After the establishment of remoralization, the patient moves into the phase of remediation in which actual symptom reduction takes place. Most patients terminate treatment after this phase. Those patients who continue with treatment progress to the last phase: rehabilitation. The temporal relation between the different phases of psychotherapeutic change is thus a basic assumption underlying the phase model of psychotherapy outcome. Another basic assumption concerns the conditional relation between the phases: Significant improvement in the preceding phase is assumed to be a necessary condition for improvement in the next phase. In other words, remoralization must take place *before* symptom reduction can occur, and symptom reduction must take place *before* rehabilitation can occur.

Given the simplicity and transparency of the phase model in addition to its detailed description of the phases of psychotherapeutic change, the model has proved attractive and theoretically valuable for clinicians. Clinicians recognize the phases for all kinds of patients (Joyce, Ogrodniczuk, Piper, & McCallum, 2002). The question, of course, is whether the phase model has been shown to be empirically valid or not. At first sight, the model appears to be empirically valid because six early studies — including four by the research team of Howard — have confirmed the basic assumptions underlying the phase model (Barkham, Rees, Stiles, Shapiro, Hardy, &

Reynolds, 1996; Hilsenroth, Ackerman, & Blagys, 2001; Howard et al., 1993; Kopta, Howard, Lowry, & Beutler, 1994; Lutz, Lowry, Kopta, Einstein, & Howard, 2001; Martinovich, 1998). Three later studies, however, have not yielded further confirmation of the assumptions underlying the phase model (Callahan, Swift, & Hynan, 2006; Holloway, 2004; Joyce et al., 2002).

In the following, the empirical evidence for aforementioned basic assumptions underlying the phase model will be considered in greater detail. Only the first two phases of the model will be considered in doing this because only a minority of patients undergoing psychotherapeutic treatment are expected to stay in therapy long enough to enter the third phase of psychotherapeutic change (Howard et al., 1993).

Previous studies

In a total of five studies (Barkham et al., 1996; Hilsenroth et al., 2001; Howard et al., 1993; Kopta et al., 1994; Lutz et al., 2001), the amount of change in remoralization and symptom reduction for patients receiving treatment was dichotomized as "improved" or "non-improved" in order to examine the temporal relation of the first two phases in the phase model. The authors compared the percentages of patients who had improved for remoralization (i.e., the first phase) and for symptom reduction (i.e., the second phase) at different points across the course of treatment. The period of treatment could range from pre-treatment to an average of 16 sessions for Kopta et al. and Lutz et al. to as many as 52 sessions. The results showed that a larger percentage of patients improved on remoralization than on symptom reduction. This finding led the authors of the five studies to conclude that remoralization of patients in psychotherapy occurs faster than symptom reduction and that psychotherapeutic change thus occurs in the stepwise manner proposed by the phase model.

However, this conclusion appears to have been rather rash. Whether or not symptom reduction (i.e., remediation) actually constitutes a *later* phase of change than remoralization cannot be deduced on the basis of the data analyzed in these studies. This is because the ratio of patients improved on remoralization to patients improved on symptom reduction did not change over time; that is, the ratio was *stable* across the course of treatment. As far as we can ascertain, the ratio of patients improving for remoralization to patients improving for symptom reduction did not differ for earlier versus later sessions although a changed ratio might be expected on the basis of the phase model. The reported data, thus, do not provide conclusive evidence for the assumption of a temporal relation of phases underlying the phase model. Unpublished findings from Martinovich (1998) may point in a different direction, but they could not be retrieved for inspection.

In three studies that were particularly aimed at examining the assumption that remoralization is a pre-condition for remediation (i.e., symptom reduction), crosstabs and chi-square analyses were undertaken to compare the numbers of improved versus

non-improved patients during the course of treatment (Callahan et al., 2006; Joyce at al., 2002; Howard et al., 1993). The question was just how many patients showed improved remoralization without symptom reduction versus no remoralization but clear symptom reduction at a given point in treatment. If the remoralization and remediation phases of the phase model are conditionally related, the first (i.e. improved remoralization and non-improved symptom reduction) should show greater numbers than the latter (non-improved remoralization and improved symptom reduction). However, only Howard et al. found such a distribution of improvement and non-improvement. Neither Callahan et al. nor Joyce et al. found the expected distribution for the majority of the treatment points that they analyzed. Given these contradictory findings, definite conclusions cannot thus be drawn about the pre-condition assumption underlying the phase model.

For all studies of the phase model, a number of methodological concerns must be addressed also. In the studies by Barkham et al. (1996), Callahan et al. (2006), Hilsenroth et al. (2001), Howard et al. (1993), Joyce et al. (2002), Kopta et al. (1994), and Lutz et al. (2001) the use of dichotomized data to indicate improvement may have led to a significant loss of information (Cohen, 1990). And as a result of this loss of information, an unnecessary increase in the likelihood of erroneous conclusions may thus have occurred. In addition, general symptom checklists were used to measure the reduction of symptoms in a number of the studies (i.e., Callahan et al.; Hilsenroth et al.; Howard et al.; Joyce et al.; Kopta et al.; Lutz et al.). However, such checklists are designed to measure *general* feelings of discomfort as opposed to specific symptoms. The question, thus, is whether these instruments were suited to distinguish the remediation (i.e., symptom reduction) phase from the remoralization phase. Finally, the studies have used heterogeneous or unclear patient samples and the type of treatment was either unspecified or the treatment was aimed at a wide array of syndromes and problems, which leaves what the observed effects of treatment should be ascribed to unclear.

As opposed to the other prior studies of the phase model, Barkham et al. (1996) examined a uniform patient population using a symptom-specific instrument. Unfortunately, the *same* instrument was used to measure both symptom reduction and remoralization, which makes it difficult to pinpoint the changes that belong to remoralization and the changes that belong to remediation. Both Joyce et al. (2002) and Holloway (2004) collected observational data, which meant that these studies did not suffer from a potential loss of information due to the dichotomization of data. Empirical proof for the assumption of a temporal relation of the phases in the phase model was not found, but proper pre-treatment assessment did not take place. Initial assessment only took place after the fourth treatment session in the Joyce et al. study, and initial assessment only took place after one or two treatment sessions in the Holloway study. In other words, important changes in remoralization might have already occurred prior to initial assessment in these studies.

In light of the contradictory findings and methodological drawbacks of the previous studies of the phase model, clear conclusions regarding the assumptions of a temporal relation and conditional relation between the phases cannot be drawn as yet.

Current study

In addition to the aforementioned contradictory findings and methodological drawbacks, previous studies of the phase model all refrained from the provision of treatment in line with the content of the phase model. According to Howard et al. (1993), "certain classes of interventions are appropriate for different phases of therapy" (p. 679). In the phase model, it is indeed presumed that different topics should be addressed during different phases of therapy, but none of the studies testing the phase model to date — including that of Howard et al. — have either experimentally or quasi-experimentally, tested this presumption. The present study was therefore specifically designed to do just this: To experimentally investigate the treatment implications of the phase model.

In order to investigate the treatment implications of the phase model, treatment was divided into two components: a brief treatment strictly focused on remoralization and a brief treatment strictly focused on the reduction of symptoms of a specific disorder. The brief treatments were then offered in either a sequence reflecting the phase model (i.e., treatment aimed at remoralization first and then treatment aimed at symptom reduction) or in a sequence deviated from the phase model (i.e., treatment aimed at symptom reduction first and then treatment aimed at remoralization). It was expected that, if the phase model is a valid model of psychotherapeutic change, treatment in line with the phase model should be more effective than treatment deviated from the model.

Many of the problems associated with the previous studies of the phase model are avoided in the present study. A homogeneous sample of patients suffering from panic disorder with agoraphobia is studied. Patients are randomly assigned to one of two treatment conditions or a waiting list. Treatment effects are assessed using observational as opposed to dichotomized data. And instruments are used to measure specifically remoralization and specific symptoms of panic with agoraphobia.

Method

Design

In an experimental study, patients with panic disorder with agoraphobia (PDA) were randomly allocated to one of three conditions: 8 weeks of treatment consisting of a 4-session remoralization module followed by a 4-session exposure module directed at the

patients symptoms (RT-ET), 8 weeks of treatment consisting of a 4-session exposure module followed by a 4-session remoralization module (ET-RT), or an 8-week waiting list (WL). Given that the 8-week treatment periods involved two separate treatment components, the term "module" is used to refer to the different components. Measurement was undertaken at Time 1 (T1), prior to randomization; at Time 2 (T2), 5 weeks later, which meant that all of the patients in the treatment conditions had completed their fourth treatment session; and at Time 3 (T3), 9 weeks after T1, which meant that all of the patients in the treatment conditions had completed their eighth and final treatment session.

We investigated whether RT-ET produced larger increase of remoralization and a larger reduction of panic symptoms than ET-RT at T3. The comparison of the T1 and T2 data of the present sample is outlined in greater detail elsewhere in order to answer another set of research questions (Vissers, Keijsers, Kampman, Hendriks, & Rijnders, 2010). The study was approved by the Dutch Central Committee for Human Related Research (i.e., ethical research committee).

Participants and procedure

A total of 150 patients from an outpatient clinic, the Pro Persona Center for Anxiety Disorders *Overwaal*, was invited at intake to participate in the present study when they met the inclusion criteria. The intake at the clinic involved two sessions. The Mini International Neuropsychiatric Interview (Lecrubier et al., 1997) was administered by independent assessors in order to determine the DSM-IV classification for the patients' disorders. The inclusion and exclusion criteria for the present study were, in line with the criteria used in efficacy studies for the treatment of panic disorder with agoraphobia (Westen & Morrison, 2001), as follows: a present DSM-IV classification of PDA and an age of 18 to 65 years. The exclusion criteria were: receipt of other psychological treatment, meeting the DSM-IV criteria for a severe mood disorder with or without psychotic features, schizophrenia, mental retardation, suicidal ideation, and alcohol or psychoactive substance abuse or dependence.

When judged to be eligible for inclusion in the study, the patients were given written information about the study and asked to provide permission to be contacted by phone. Those patients who agreed to be contacted were called within one week after the second intake session. The study was explained in greater detail. The patients were invited to participate in the study while awaiting for their formal treatment to begin. The waiting time from intake to initiation of outpatient treatment was an average of 5.5 months at the time of the start of the present study.

A total of 95 patients agreed to participate. At T1, the patients were asked to provide their written informed consent. They were then asked by an independent assessor to complete three self-report scales to determine their state of remoralization and symptoms (see Measures). At the end of T1, the patients were randomly assigned to

one of three conditions (i.e., a three-arm parallel trial design was followed). Randomization was carried out for successive blocks of 15 subjects (5 ET-RT, 5 RT-ET, and 5 WL) in order to arrive at equal numbers of patients per condition. Stratification was adopted for the use of antidepressant medication.

One week after T1, weekly treatment sessions were initiated with the patients in the two treatment conditions. At the end of the fourth session (T2) and at the end of the eighth session (T3), the patients were again asked to complete the three self-report scales. The patients in WL were invited to the clinic to also complete the three self-report scales 5 weeks (T2) and 9 weeks (T3) after initial assessment.

In the end, 72 patients completed the study; the demographic characteristics are summarized in Table 1. In addition to a DSM-IV axis I disorder, two of the patients also had a co-morbid DSM-IV axis II disorder: one in RT-ET and one in WL. Of the 30 patients taking antidepressants, 26 had SSRIs and 4 had a tricyclic or other antidepressant. Of the 26 patients taking benzodiazepines, 10 were taking an antidepressant as well. All of the patients taking psychotropic medication were asked to adhere to the set daily dosage throughout the study.

Treatment modules

General aspects. The patients in RT-ET and ET-RT all received two treatment modules but in a different sequence. Both modules involved four weekly sessions with a duration of 45 minutes each; the individual sessions were outlined in a manual. After each session, homework was assigned. Each module was piloted on five PDA patients. The treatment was provided by two therapists: one for each treatment module.

All of the sessions were audiotaped for supervision purposes and to check for treatment integrity. With regard to the latter, 15% of the audiotaped sessions were selected at random. A graduate teaching assistant, who was naive with regard to the content and goals of the present study, listened to the audiotapes and used a checklist to indicate if the main features of the two modules were present or not. This resulted in a 100 % correct classification (i.e. either RT or ET) for all of the selected sessions.

Remoralization treatment module (RT). The four-session remoralization treatment module was derived from the work of Rijnders (2004) who has developed a brief therapy aimed at the remoralization of patients. Rijnders' brief therapy involves seven or eight sessions and is strongly based upon Frank's demoralization theory but also contains elements of strategic psychotherapy, behavior therapy, and solution-focused therapy. Hakkaart-van Roijen, van Straten, Rutten, and Donker (2006) have shown this therapy to be just as effective as cognitive behavior therapy and also care as usual (i.e., a therapy from a wide range of options).

In the RT module, attention was not paid to specific PDA symptoms but, rather, to the explanation of the problems experienced by the patient in terms of failed problem solving and inadequate coping strategies. The RT was aimed at identification of the

patient's competencies and stimulation of these competencies via step-by-step problem solving training. The goal of the RT was not to reduce symptoms but to elicit perspective and hope. In the first session, a hypothesis about the relationship between the patient's problems and his or her circumstances was sought. The patient was then instructed to think and talk about the circumstances that appear to make his or her usual problem-solving strategies fail as a homework assignment. In the second session, the patient's hypothesis was extended to include his or her personal coping style: The patient's problems can be viewed as a result of his or her particular circumstances and specific manner of coping. In the remainder of the sessions, behavior-change experiments were proposed, discussed, and carried out by the patient. Although the therapists in the RT module had to acknowledge the suffering of the patients at times, they refrained from directly intervening to reduce the incidence of symptoms.

Exposure treatment module (ET). Development of agoraphobia is seen as an aggravation and complication of panic disorder and often considered the most impairing aspect of PDA (Barlow, 1988; de Beurs & Widenfelt, 2004). For this reason, exposure in-vivo, directly aimed at the agoraphobia, was decided upon as the course of treatment for the symptoms of PDA in the present study. The exposure in-vivo component is one of the four components of the repeatedly tested and clearly effective Panic Control Treatment (PCT) of Craske and Barlow (1993; van Balkom, Bakker, Spinhoven, Blaauw, Smeenk, & Ruesink, 1997). This component has been shown to clearly contribute to the effectiveness with respect to symptoms of PCT (de Beurs, van Balkom, Lange, Koele, & van Dyck, 1995).

In the first ET session, psycho-education about anxiety and avoidance behavior was undertaken and, together with the therapist, the patient constructed a hierarchy of relevant phobic situations. The patient was then given the assignment to expose him/herself to a phobic situation, guided by the hierarchy of these situations, before the next session (i.e., the second, third, or fourth treatment session). The exposure assignment was then evaluated and discussed during the next treatment session. In the ET sessions, no problems other than the patient's agoraphobic avoidance were discussed. If a patient started to talk about other problem areas, the therapist politely brought the focus back to the exposure assignment and hierarchy of phobic situations. The therapist took a supportive, coaching stance and encouraged the patients to perform the exposure assignments.

Therapists and assessors

Therapists were graduate students in clinical psychology fulfilling their practical internship at the Pro Persona Centre for Anxiety Disorders *Overwaal* or at a university outpatient clinic. All of the therapists received a two-day training in ET and a two-day training in RT. Throughout the study, the therapists were supervised on a weekly basis by two experienced clinical psychologists: one who is specialized in exposure treatment

and one who is specialized in remoralization treatment. In such a manner, adherence to the treatment manuals was ensured. Audiotaped recordings of the sessions were used for the supervision sessions.

The assessors at T1, T2 and T3 were also graduate students in clinical psychology fulfilling their practical or research internship but different from the therapists. The assessors were blind to the treatment conditions for the patients being assessed.

Measures

Remoralization was measured using two self-report instruments. The Subjective Well-being Scale (SWS; Grissom, Lyons, & Lutz, 2002), which is a three-item adaptation of the original instrument used by Howard et al. (1993) to assess remoralization. The three items constituting the SWS are responded to using Likert scales with a range of 1 to 4, 1 to 5, and 1 to 6, respectively. The SWS has good internal consistency and validity. High scores indicate strong remoralization. The SWS is treated as the primary measure of remoralization in the present study because it corresponds most to the measures used in the original studies of the phase model. However, the usefulness of the SWS is unknown for cases of PDA. The Remoralization Scale (RS; Vissers, Keijsers, van der Veld, de Jong, & Hutschemaekers, in press), which is a measure of remoralization recently developed and tested on a population of patients with PDA, was therefore included as a secondary measure of remoralization in the present study. The RS assesses changes in remoralization as a result of treatment. The RS is a psychometrically sound instrument that measures growth of hope, subjective well-being, and sense of mastery. Patients are required to rate on a four-point scale the extent to which they agree with each of 12 statements, with higher RS scores indicating greater remoralization. Internal consistency and test-retest reliability are excellent (Vissers et al.).

The Panic and Agoraphobia Scale (PAS; Bandelow, 1995) was used to measure symptoms of panic and agoraphobia. The PAS is a psychometrically sound self-report instrument that requires respondents to respond to 13 items using a four-point Likert scale. The incidence of panic attacks, avoidance behavior, anticipatory anxiety, disability, and worries about health is assessed. A higher PAS score indicates more symptoms of panic and agoraphobia.

Data analyses

Analyses were conducted on the data for completers (ET-RT, n = 27; RT-ET, n = 26; WL, n = 19). For the main analyses of the data, change scores were calculated (i.e., T1 minus T3). Each change score was entered separately into a one-way ANCOVA — one for SWS, one for RS, and one for PAS — with three conditions (ET-RT, RT-ET, WL) and the T1 scores as the covariate. After checking for a main effect of condition,

planned contrasts were undertaken (Maxwell & Delaney 2004): The change scores for ET-RT were compared to those for WL, and the change scores for RT-ET were compared to those for WL. Thereafter, the main question, whether RT-ET was indeed more effective than ET-RT, was investigated using again three separate ANCOVAs with three conditions (RT-ET, ET-RT, WL). Planned contrasts were directly undertaken: change scores for ET-RT were compared to those for RT-ET.

There were no missing data for the primary measures (SWS and PAS). Due to a logistic failure, 25% of the data for the secondary remoralization measure was missing but completely at random. For this reason, we used multiple imputation (Little & Rubin, 1990; Rubin, 1987). That is, we imputed 10 data sets and averaged predictions and *SE*s for uncertainty due to imputation.

Results

Attrition

As can be seen from Figure 1, 150 patients were found to be potentially eligible for inclusion in the study and 126 met the inclusion criteria. A total of 95 agreed to participate and were randomly assigned to one of the three conditions at T1. Immediately thereafter, 4 patients dropped out. An additional 13 patients dropped out just before T2 and 6 before T3. When the scores on the two measures of remoralization and the scores on the measure of symptoms at T1 were compared for the dropouts versus the completers, significant differences did not occur.

Data collection was conducted between December 2005 and November 2008. While the required sample sizes had yet to be obtained by November 2008, the average waiting time for the outpatient clinic had dropped to less than nine weeks, which rendered inclusion in our study impossible.

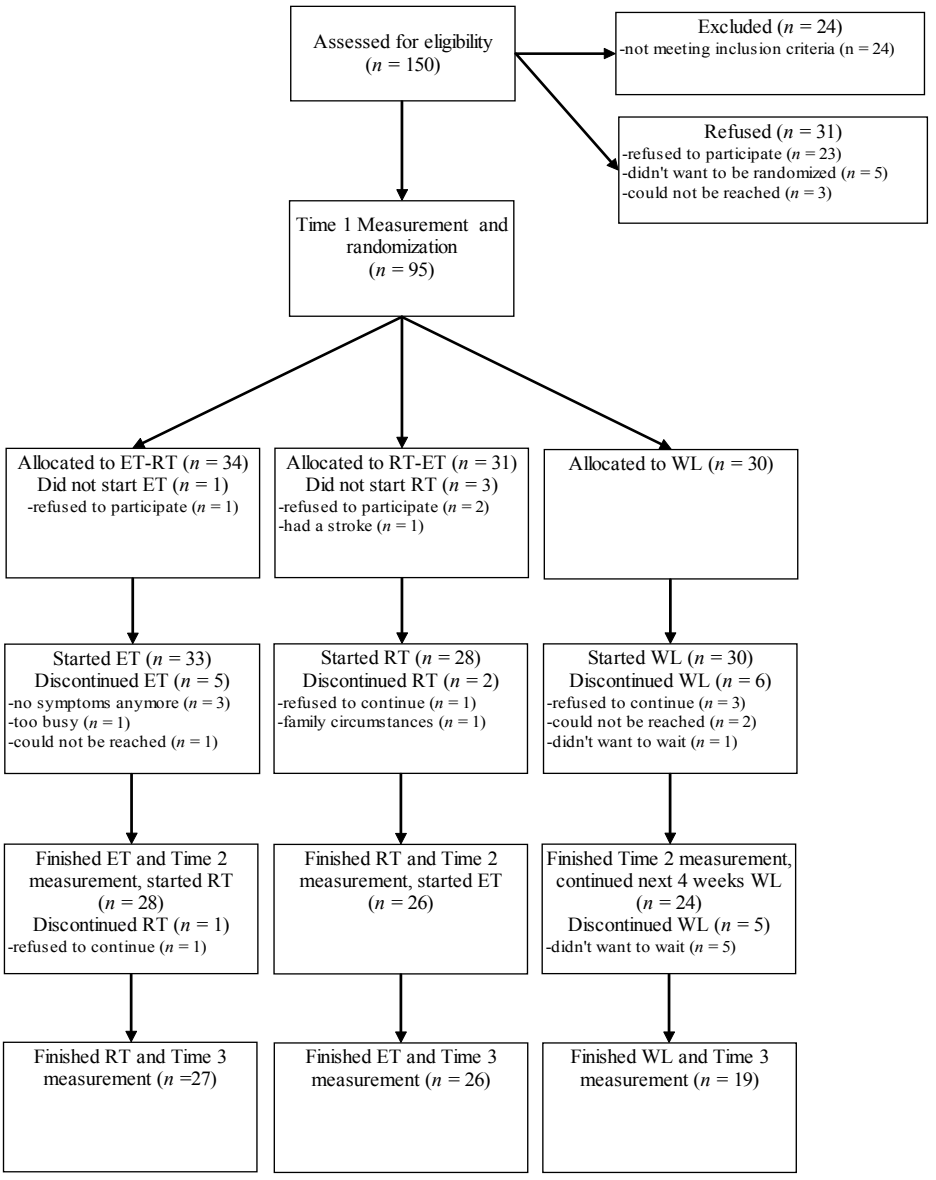

Figure 1. Overview of patient participation and dropout. ET-RT = exposure treatment module followed by remoralization treatment module, RT-ET = remoralization treatment module followed by exposure treatment module, ET = exposure treatment module, RT = remoralization treatment module, WL = waiting list control.

Preliminary analyses

ET-RT, RT-ET, and WL groups did not differ with regard to demographic characteristics (see Table 1).

Table 1.
Demographic and Clinical Characteristics of Patients.

Variable	ET-RT *n* = 27	RT-ET *n* = 26	WL *n* = 19	Test value (*df*)	*p*
Age, years (*SD*)	33.2 (11.3)	37.8 (13.1)	29.9 (14.0)	F (2,69) = 1.71	.19
Male, % (*n*)	33.3 (9)	23.1 (6)	47.4 (9)	χ^2 (2) = 2.92	.23
Education, years (*SD*)	12.2 (2.1)	11.7 (2.7)	12.1 (3.2)	F (2,68) = 0.29	.75
Marital or living status:				χ^2 (4) = 3.48	.48
Never married, % (*n*)	48.1 (13)	38.5 (10)	36.8 (7)		
Divorced, % (*n*)	00.0 (0)	11.5 (3)	06.9 (2)		
Married or living with partner, % (*n*)	51.9 (14)	50.0 (13)	52.6 (10)		
Employed, % (*n*)	69.6 (16)	54.2 (13)	55.6 (10)	χ^2 (2) = 1.37	.51
Panic symptoms, years (*SD*)	05.1 (6.3)	05.8 (8.0)	07.6 (11.5)	F (2,66) = 0.47	.63
Co-morbidity, % (*n*)	66.7 (18)	42.3 (11)	42.1 (8)	χ^2 (2) = 4.04	.14
Sort co-morbidity:					
Depression, % (*n*)	22.2 (6)	11.5 (3)	05.3 (1)		
Hypochondria, % (*n*)	18.5 (5)	11.5 (3)	05.3 (1)		
Social phobia, % (*n*)	14.8 (4)	07.7. (2)	15.8 (3)		
GAD, % (*n*)	11.1 (3)	07.7. (2)	15.8 (3)		
Specific phobia, % (*n*)	14.8 (4)	03.8 (1)	10.5 (2)		
OCD, % (*n*)	11.1 (3)	03.8 (1)	05.3 (1)		
Other, % (*n*)	07.4 (2)	11.5 (3)	00.0 (0)		
Antidepressant, % (*n*)	40.7 (11)	46.2 (12)	36.08 (7)	χ^2 (2) = 0.41	.82
Benzodiazepine, % (*n*)	25,9 (7)	42.3 (11)	42.1 (8)	χ^2 (2) = 1.94	.38

Note. ET-RT = exposure treatment module followed by remoralization treatment module, RT-ET = remoralization treatment module followed by exposure treatment module, WL = waiting list control. GAD = generalized anxiety disorder, OCD = obsessive compulsive disorder, AD = adjustment disorder.

In Table 2, the T1, T2, and T3 scores for the three outcome measures and the estimated effect sizes for the three groups of patients are presented. After checking for the basic assumptions of multivariate normality and homogeneity of variance, whether or not the three groups differed from baseline on the SWS, RS, and PAS measures was tested. The

overall MANOVA did not yield a significant Wilks' Lambda, F (6, 136) = 1.39, p = .22. An alpha level of .05 was used for all statistical tests.

Table 2.
Descriptive Statistics for Outcome Measures at T1, T2, and T3.

Measure/ condition (n)	T1 M (SD)	T2 M (SD)	T3 M (SD)	ES[a] T1-T2	ES[a] T2-T3	ES[a] T1-T3
SWS						
ET-RT (27)	3.11 (0.58)	3.59 (0.68)	3.52 (0.72)	0.75	–0.10[b]	0.61
RT-ET (26)	2.76 (0.66)	3.30 (0.85)	3.41 (0.80)	0.70	0.13	0.88
WL (19)	2.79 (0.76)	2.91 (0.81)	2.84 (0.83)	0.15	–0.08 [b]	0.06
RS						
ET-RT (27)	2.65 (0.43)	2.86 (0.51)	2.86 (0.52)	0.43	0.00	0.43
RT-ET (26)	2.56 (0.52)	2.90 (0.38)	2.82 (0.48)	0.75	–0.18 [b]	0.52
WL (19)	2.42 (0.50)	2.48 (0.56)	2.44 (0.52)	0.10	–0.06 [b]	0.04
PAS						
ET-RT (27)	1.68 (0.70)	1.17 (0.68)	1.06 (0.70)	0.73	0.16	0.87
RT-ET (26)	1.68 (0.79)	1.23 (0.83)	1.13 (0.87)	0.55	0.11	0.65
WL (19)	1.89 (0.80)	1.80 (0.93)	1.70 (0.78)	0.11	0.11	0.24

Note. SWS = Subjective Well-being Scale, RS = Remoralization Scale, PAS = Panic and Agoraphobia Scale, ET-RT = exposure treatment module followed by remoralization treatment module, RT-ET = remoralization treatment module followed by exposure treatment module, WL = waiting list control group.
[a]Estimated effect size was calculated as Hedges' g $(M1 - M2)/SD$pooled; SDpooled = $\sqrt{([(n1 - 1)SD1^2 + (n2 - 1)SD2^2]/n1 + n2 - 2)}$.
[b]Minus signs indicate an effect size for T2-T3 in the opposite direction of the effect size for T1-T2.

ANCOVAs were conducted next. Each of the covariates (i.e., measures at T1) for the three outcome measures were significantly related to the change scores: SWS: F(1, 68) = 6.76, p = .011, RS: F(1,68) = 7.14, p = .010, and PAS: F(1, 68) = 11.14, p = .001. For all three measures, the condition effect was significant: SWS: F(2, 68) = 5.14, p = .008, RS: F(2, 68) = 4.23, p = .021, and PAS: F(2, 68) = 4.15, p = .020. Planned contrasts showed ET-RT compared to WL to elicit significantly greater changes in the SWS (t[68] = 2.35, p = .022), the RS (t[68] = 2.46 , p = .018), and the PAS (t[68] = 2.74, p = .008). Planned contrasts similarly showed RT-ET compared to WL to elicit significantly greater changes in the SWS (t[68] = 2.13, p = .003.), the RS (t[68] = 2.73, p = .011), and the PAS (t[68] = 2.33, p = .023). Both ET-RT and RT-ET thus resulted in increased remoralization and decreased in panic-disorder symptoms.

Treatments compared

Recall that the main aim of the current research was to determine if RT-ET was more effective than ET-RT as might be expected on the basis of the phase model. Planned contrasts showed RT-ET to *not* elicit significantly stronger increases relative to ET-RT

for SWS, $t(68) = 0.80$, $p = .426$, for RS, $t(74) = 0.31$, $p = .741$, or for PAS, $t(68) = 0.43$, $p = .668$. There were no significant differences between the two treatments with respect to the amount of change for the three outcome measures.

Discussion

The aim of the present study was to investigate whether a treatment designed in line with the phase model (RT-ET) of Howard et al. (1993), was more effective than a treatment designed to clearly deviate from this model (ET-RT). In an experimental design, the two different treatments were compared in terms of their effects on remoralization and symptom reduction in patients with PDA. The different treatments were also compared to a waiting list control condition (WL).

The results showed both treatments to increase remoralization (SWS and RS) and reduce panic disorder symptom (PAS) relative to WL. These effects were moderately large, but in line with those reported for remoralization (Ermers, 2005) and panic symptoms (de Beurs et al., 1995) when brief treatment modules have been offered.

When the two treatments in the present study were directly compared, RT-ET was not found to be more effective than ET-RT. These findings held for not only the measures of remoralization but also the measure of symptom reduction.

The lack of differential effects for RT-ET and ET-RT might, of course, be due to the RT and ET modules not being sufficiently distinct. This does not, however, appear to be the case as the check for treatment integrity was 100% correct, which indicates that two clearly distinct treatment modules were indeed administered to all patients in the treatment conditions, but in different orders. Should the present findings be replicated, it can then be concluded that treatment that immediately starts with addressing patients' symptoms is just as effective as treatment that first considers the patient's state of hopelessness in order to provide some perspective and thereby hope, that is, as far as panic disorder patients are concerned.

In order to explain why RT-ET *fails* to be more effective than ET-RT, several explanations are possible and one of these is particularly likely in our opinion. While two *distinct* treatment modules were constructed and administered with 100% treatment integrity in the present study, it is nevertheless possible that the psychological processes associated with remoralization and symptom reduction co-occur and co-vary. Akin to thunder and lightning, it is thus possible that remoralization and symptom reduction are different psychological processes but cannot be experienced separate of each other. It is possible, for example, that symptom reduction cannot take place without remoralization and, conversely, remoralization cannot take place without symptom reduction. Reduced fear, less avoidance, and fewer panic attacks can certainly foster a more realistic perspective on the part of a patient and thereby foster hope; conversely, greater

perspective and hope can reduce symptoms of anxiety and ease the negative impact of such to at least a certain degree.

Calculation of the correlations between the changes in the remoralization measures (T1-T3) and the changes in the symptom measures (T1-T3) yielded a mean of –.54 (range: –.52 to –.57), which shows 29% of the change in one measure to be explained by changes in the other measure. This is a considerable amount of explained variance. In other words, remoralization and symptom reduction may indeed co-occur and co-vary.

The effect sizes presented in Table 2 show the largest proportion of change to be realized by the first module in both of the treatments. The explanation for this effect is not completely apparent, but it is in line with the *diminishing returns effect* (Howard, Kopta, Krause, & Orlinsky, 1986). The diminishing returns effect is a change pattern frequently found to occur in psychotherapeutic treatment and entails rates of patient change leveling off after a particular point and further treatment not producing the same acceleration as seen earlier in treatment. Largest change was indeed found for the first module, yet, again, RT-ET and ET-RT did not differ with respect to these findings.

The main limitation on the present study is the small sample size involved. It might be argued that we therefore had too little power to detect meaningful differences between RT-ET and ET-RT. Replication is certainly required. However, the study was carefully conducted, integrity of treatment was high, and the treatment modules were carefully selected, conducted, and supervised. Furthermore, both treatments produced better results than WL along on all of the outcome measures. We have no indication to believe that a larger patient sample would have yielded completely different results. In a replication study, it would be interesting, however, to include a follow-up measure to investigate possible differences between the two treatments several months following the last treatment session.

The attrition rate of 24% in the present study from T1 (i.e., the moment of allocation) to T3 (i.e., post-treatment) may seem quite high but is commonly reported for patients with PDA (see, for instance, Barlow, Gorman, Shear, & Woods, 2000; Keijsers, Kampman, & Hoogduin, 2001). Approximately 50% of the dropouts in the present study were patients who had been assigned to WL. Most of these patients reported an unwillingness to await formal treatment any longer or a loss of interest in study participation. In the treatment conditions, the dropout rates from the first session (i.e. patients had experienced at least one session of the allocated treatment) to T3 were not equally distributed. More patients dropped out from ET-RT (6) than from RT-ET (2). Speculation as to why RT-ET may might be easier for the patient to continue than ET-RT is tentative, due to the small number of patients involved and because three out of the six patients who dropped out of ET-RT stated that their dropout was due to the fact that they had no symptoms left.

Although the present study is small-scale and the present findings must therefore be considered preliminary, the study is innovative in that it is the first to investigate the implications of the phase model via the design of the treatments (in line with, or deviated from, the phase model) and careful control of the treatment provided. The treatment effects were evaluated using the sophisticated standards for randomized clinical trials. The brief treatments were designed along the lines of treatment-analogous laboratory manipulations, which means that the methodological sophistication of laboratory experiments was combined with the ecological validity of real treatment with real patients. One might nevertheless suggest that the design and use of the brief treatments had little ecological validity but, in our opinion, such a treatment-analogous laboratory design was necessary to avoid the many problems associated with previous studies of the phase model.

With the use of patients with PDA (i.e., a specific patient population), we were able to investigate symptom reduction specifically and validly as opposed to the previous studies of the phase model that used general symptom checklists. The present approach methodologically enlarged the a priori chances of detecting distinct effects of remoralization and symptom reduction. However, the findings cannot, as a result of the homogeneous patient population, be generalized to other patient populations such as patients with more chronic than acute syndromes like schizophrenia, because in such cases symptom reduction is less likely to occur than remoralization (Shrivastava, Johnston, Shah, & Bureau, 2010; Strauss, 1994).

The studies discussed in the Introduction (Barkham et al., 1996; Callahan et al., 2006, Hilsenroth, 2001; Howard et al., 1993; Holloway, 2004, Joyce et al., 2002; Kopta et al., 1994; Lutz et al., 2001) did not provide a conclusive answer to the question of whether the basic assumptions of temporal relation and conditional relation for the first two phases of the phase model are empirically valid. The lack of conclusive evidence of these studies could be attributable to methodological problems. However, in the present study with its innovative design and careful methodology, we also did not find evidence for an important treatment implication of the phase model, namely that a treatment first focussed on the first phase of the model (remoralization) should elicit more change than a treatment immediately focused on the second phase (symptom reduction). Frank (1974) and Howard et al. (1993) were right in their assumption that successful psychotherapy produces multiple effects: symptom reduction, on the one hand, and remoralization, on the other hand. However, in line with the results of previous studies, no additional proof in the direction of the phase model has been found.

Chapter 6. Summary and General Discussion

Background

There is a shortcoming in current outcome research of psychotherapy for patients in mental health care. As described in Chapter 1, the main question for the current research generation is whether a specific treatment effectively reduces the symptoms of a specific disorder. Although highly important, symptom reduction does not seem the only beneficial effect of treatments judged to be effective. However, other beneficial effects of psychotherapy have hardly been investigated in current psychotherapy outcome research. That is, the extent to which patients experience for example positive changes in their subjective sense of well-being, a better quality of social relationships, an increased sense of control, and reduced hopelessness has been neglected. Such a one-sided emphasis on symptom reduction as the only important measure of psychotherapeutic outcome, moreover, has become so pervasive in outcome research today that a treatment is now referred to as "effective" without stipulation that "effective" means "effective with respect to symptom reduction."

In response to this one-sided focus on symptom reduction, there is a call to adopt a broader perspective on the measurement of effects in psychotherapy outcome research today. Remoralization is a promising supplementary outcome measure to broaden the scope of research on the beneficial effects of psychotherapy. In addition to symptom reduction, that is, remoralization can be expected to occur as a result of successful psychotherapy. Remoralization describes a valuable positive change that is independent of a specific therapeutic tradition. When patients remoralize, they regain hope and perspective; they learn to trust that a solution to their problems will become available. The state of demoralization — which is a state of isolation and despair (Frank, 1974) — decreases during remoralization.

Frank stated that people who enter into psychotherapeutic treatment not only suffer from a specific mental disorder (i.e., experience symptomatic burden) but typically feel demoralized as well. Frank thus assumed that effective treatment should realize both: remoralization and symptom reduction. In assuming this, Frank indirectly suggested that remoralization and symptom reduction may constitute separate processes during the course of treatment. In the renowned *phase model of psychotherapy outcome* (phase model; Howard, Lueger, Malin, & Martinovich, 1993), remoralization and symptom reduction are also described as two successive phases during the course of psychotherapeutic treatment.

Remoralization can theoretically be seen to make a valuable contribution to outcome research by broadening the perspective with respect to the effectiveness of psychotherapy, but the actual surplus value of remoralization remains unclear due to a lack of research on remoralization within the context of outcome research. Whether or not remoralization can be adequately measured, and whether or not measures of remoralization are sufficiently sensitive to changes as a result of psychotherapy, has

been unclear. Further, whether or not the measurement of remoralization can increase our understanding of the beneficial effects of psychotherapies has been unclear. Can new insights into the effects of psychotherapy be gained with the measurement of remoralization? Is the information provided by the measurement of remoralization supplementary, contradictory, or redundant to that provided by the measurement of symptom reduction? It is possible, for example, that the measurement of remoralization fails to provide greater insight into our current understanding of the effects of psychotherapy when measured in terms of symptom reduction, because it cannot be measured adequately or it cannot sufficiently de differentiated from symptom levels. The main question in the present dissertation was therefore as follows: Is remoralization a valuable outcome measure supplementary to the measurement of symptom reduction in psychotherapy outcome research?

In this closing chapter, a summary of the findings of the empirical studies will first be presented. Thereafter, conclusions, and general limitations and considerations with regard to the results of these studies will be discussed. Finally, the implications of the findings will be discussed in relation to the background for this dissertation.

The empirical studies: Chapters 2, 3, 4 and 5

Chapter 2

The search for an appropriate measurement instrument to assess remoralization of mental health care patients was critical as a suitable instrument was not available at the start of this research. Therefore, the Remoralization Scale (RS) was developed and tested for adequate psychometric properties in the five studies reported on in Chapter 2. In the first study, six instruments that measured concepts associated according to the literature with remoralization were selected: self-esteem, personal empowerment, feelings of competence, optimism, sense of inner control, and hope. A pool of 69 items was derived from these instruments. The items were completed by 299 outpatients. Exploratory factor analyses were conducted, and the pool of items was reduced to 16 items constituting an initial scale with a unidimensional factor structure.

In the second study, the unidimensionality and scalar invariance of the RS was tested in a sample of 199 outpatients and 192 non-patients. It was argued that the RS should measure the same construct in the same way for both patients and non-patients. A multi-group confirmatory factor analysis was conducted. To make the RS as short and easy to complete as possible, 4 items with low factor loadings were removed. The definitive version of the RS with a total of 12 items was the result. Factor analysis further confirmed the unidimensionality and scalar invariance of the final RS and showed the patients and non-patients to understand the items of the RS in a similar manner. The RS thus measured the same concept for patients and non-patients.

In the third study, the test-retest reliability and internal consistency of the RS were tested using a sample of 124 students. The test-retest reliability of the RS across a period of one week was found to be good (r = .89). The internal consistency of the RS was also found to be good (α = .87). The Cronbach's alphas for the patient sample (α = .91) in Study 2 and the non-patient sample (α = .91) in Study 2 were comparable to that for the student sample. The internal consistency of the RS was thus judged to be high and similar across different samples. Furthermore, the removal of the four items, as described in Study 2, had only a negligible effect upon the internal consistency of the RS as the Cronbach's alpha for the initial 16-item version of the RS was .92.

In the fourth study, the validity of the RS was determined. First, the RS was shown to differentiate between patients and non-patients (see Study 2) as non-patients were found to be significantly and considerably more remoralized than patients (Effect Sizes [*ES*] = 1.87). The construct validity of the RS was next investigated by examining the correlations of the RS scores with scores on other relevant measures for mental health care patients. The RS scores showed high negative correlations with Demoralization Scale scores (r = –.72; Kissane, Wein, Love, Lee, Kee, & Clarke, 2004) and high negative correlations with symptoms of anxiety (r = –.52) and level of depression (r = –.50) measured using the General Health Questionnaire (Goldberg, 1972). Moderate negative correlations were also found for the RS scores with somatic symptoms (r = –.36) and social dysfunction (r = –.37) also measured by the General Health Questionnaire. It could thus be concluded that the RS shows satisfactory construct validity.

In the fifth and final study reported on in Chapter 2, the sensitivity of the RS to therapeutic change was examined in a population of 24 patients suffering from panic disorder with agoraphobia (PDA). The patients were given an empirically supported treatment for their symptoms (either cognitive behavior therapy or a drug treatment using a selective serotonin reuptake inhibitor). The patients were followed across a periods of six months and significantly improved with respect to not only panic symptoms (*ES* = 1.21) as measured by the Mobility Inventory Avoidance when Alone (Chambless, Caputo, Jasin, Gracely, & Williams, 1985) but also remoralization (*ES* = 1.51) as measured by the RS. The RS was thus shown to be sensitive to therapeutic change.

In sum, the results of five empirical studies showed the self-report RS to have high internal consistency, excellent test-retest reliability, good construct validity, good discriminative validity, and clear sensitivity to therapeutic change. With only 12 items and a unidimensional factor structure, the RS is brief and easy to administer and interpret.

Chapter 3

In the study reported on in Chapter 3, the question of whether the measurement of remoralization provides added value was taken a step further. In the literature, remoralization and symptom reduction are typically described as two distinguishable processes by de Figueiredo (2007), Frank (1974), and Howard et al. (1993). However, the relationship (i.e., correlation) between remoralization and symptom reduction were not directly investigated by the aforementioned authors.

Various studies have been conducted to test the basic assumptions underlying the phase model of Howard et al. (Barkham, Rees, Stiles, Shapiro, Hardy, & Reynolds, 1996; Callahan, Swift, & Hynan, 2006; Hilsenroth, Ackerman, & Blagys, 2001; Holloway, 2004; Joyce, Ogrodniczuk, Piper, & McCallum, 2002; Kopta, Howard, Lowry, & Beutler, 1994; Lutz, Lowry, Kopta, Einstein, & Howard, 2001; Martinovich, 1998). But unequivocal evidence to confirm the occurrence of the two phases has yet to be provided. Remoralization has yet to be clearly distinguished from symptom reduction. However, the ambiguity of these earlier findings may stem from methodological shortcomings of the studies: the use of unspecified patient samples, unspecified treatments or treatments aimed at a variety of problems and syndromes, and general symptom checklists that are thus not suited to separate remoralization from symptom reduction. It is thus unclear whether remoralization and symptom reduction overlap considerably or are, indeed, two distinct but nevertheless, maybe somewhat related, measures of psychotherapy outcome.

In a preliminary study, 24 outpatients with PDA were given an indicated, manual-based empirically supported treatment. The sample was the same as in the fifth study reported on in Chapter 2. Changes in specific symptoms of agoraphobic avoidance (Mobility Inventory Avoidance when Alone; Chambless et al., 1985) and agoraphobic cognitions (Agoraphobic Cognitions Questionnaire; Chambless, Caputo, Bright, & Gallager, 1984), and remoralization (RS) were measured every four weeks from pre- to post-assessment across a period of 28 weeks in addition to changes in health-related Quality of Life (QoL) measured using the *RAND-36* (van der Zee & Sanderman, 1994) at pre- and post-assessment.

As expected, the empirically supported treatment proved effective for symptom reduction (agoraphobic avoidance $ES = 1.21$; agoraphobic cognitions $ES = 1.19$); the change patterns were linear. The empirically supported treatment also proved effective for remoralization with also a linear pattern of change. The patients consistently were more remoralized in a subsequent interval than in the interval before for every four-week interval ($ES = 1.45$). Remoralization was thus sensitive to treatment change when administered on several occasions during the course of treatment. The slopes for agoraphobic avoidance, agoraphobic cognitions, and remoralization correlated highly in the latent growth model analyses ($r = -.50$ to $-.55$), which show similar patterns of

change over time. Despite the use of a homogeneous group of patients suffering from a particular syndrome and the use of a specific treatment aimed at the alleviation of the symptoms of that particular disorder, the course of remoralization showed a similar pattern of change as the course of symptom reduction. The symptoms of patients with PDA thus change in a similar manner and at a similar pace as their remoralization and vice versa when given an empirically supported form of treatment.

To determine if the measurement of remoralization possibly had some unique value that went unaddressed by the measures of symptom reduction, the correlations of the remoralization scores for the 24 outpatients with their health-related QoL scores were calculated. The slope for remoralization correlated with positive changes on a number of aspects of health-related quality of life, namely general health perception, mental health, bodily pain, and role limitations due to emotional problems; the slope of symptom reduction did not. In other words, when patients experience remoralization during the course of treatment, they are also more likely to report better overall feelings of health, fewer limitations in the domains of both work and daily life activities, less bodily pain, and a better general health status. Remoralization showed a high correlation with symptom reduction but a unique relationship to many aspects of an improved health-related QoL.

Using a specific patient sample, a well-indicated empirically supported treatment, and specific measures of remoralization and symptom reduction to increase the a priori chances of finding different patterns of change for remoralization versus symptom reduction, significantly different patterns of change, nevertheless, could not be detected. This finding is in line with the results of previous studies that tested the phase model (Callahan et al., 2006; Hilsenroth et al., 2001; Holloway, 2004; Howard et al., 1993; Joyce et al., 2002; Kopta et al., 1994; Lutz et al., 2001; Martinovich, 1998). Hence, it is possible to assume that the offered treatments simultaneously prompt both remoralization and symptom reduction. To help unravel the relations between remoralization and symptom reduction, an experimental study in which the effects of a treatment focused solely on remoralization and a treatment focused solely on the symptoms of a specific disorder are compared was next deemed necessary.

Chapter 4

In Chapter 4, the effects of a treatment focused solely on remoralization versus a treatment focused solely on the symptoms of a specific disorder were compared. Separate forms of treatment and the accompanying experimental research design were adopted in order to maximize the chances of being able to distinguish remoralization and symptom reduction. If remoralization and symptom reduction can be distinguished, as Frank (1973) and Howard et al. suggest in the phase model (1993), then treatment aimed specifically at remoralization should not lead to clear symptom reduction and,

conversely, treatment aimed specifically at symptom reduction should not lead to clear remoralization.

A total of 78 patients suffering from PDA were randomly assigned to a 4-week remoralization treatment (RT) with a strict focus on remoralization, a 4-week exposure treatment (ET) with a strict focus on symptoms, or a 4-week waiting list (WL). With the use of brief and strictly manualized treatments, a research design that resembles the design of laboratory experiments was thus attained for a naturalistic setting and thereby the methodological sophistication of a laboratory experiment combined with the ecological validity of the real treatment of real patients. Assessment at pre- and post-treatment (i.e., assessment after the fourth session) were undertaken. Remoralization was measured using both the Subjective Well-being Scale (SWS; Howard et al., 1993) and the RS; symptoms of PDA were measured using the Panic-Agoraphobia Scale (Bandalow, 1995). Significant improvement was found for the intended effects of the treatments compared to WL: RT produced significant remoralization ($ES = 0.70 – 0.74$) and ET produced significant symptom reduction ($ES = 0.72$). In addition, however, unintended effects of the specific treatment conditions were found when compared to WL as well: RT also produced significant symptom reduction ($ES = 0.55$) and ET produced significant remoralization as well ($ES = 0.47 – 0.76$).

In a highly controlled, experimental study using two — very different — brief treatments with 100 % treatment integrity, we were still unable to unravel the relations between remoralization and symptom reduction. It is thus unlikely, for at least patients suffering from PDA, that remoralization and symptom reduction can be distinguished empirically. This difficulty may explain why earlier studies that tested the phase model have not been able to confirm the assumptions underlying the phase model.

Chapter 5

In the phase model (Howard et al., 1993), psychotherapy is expected to progress in a stepwise manner with each phase of psychotherapy depending upon a previous phase and each phase thus constituting a different domain of psychotherapeutic change. The first phase in the model draws upon the demoralization theory of Frank and Frank (1991) and is referred to as the *remoralization phase*. The second phase addresses the symptoms of the patient and is referred to as the *remediation phase*. In the phase model, a customary sequence is assumed, namely: remoralization followed by symptom reduction. In addition, significant improvement during one phase is assumed to be a necessary condition for significant improvement in the next phase. That is, without improvement during one phase, significant improvement during the next phase cannot be expected. While several studies have examined the assumptions underlying the phase model, none have addressed the question whether a treatment designed in line with the phase model is more effective than a treatment that deviates form the phase model.

In Chapter 5, a study undertaken to answer this question is reported. The patients from the study described in Chapter 4 were followed further using the same measures administered at post-assessment. After the fourth session, the patients in the two treatment conditions (i.e., RT and ET) were now given the opposite treatment. In such a manner, two treatment conditions of eight sessions each were obtained: either four sessions of RT followed by four sessions of ET (RT-ET) or four sessions of ET followed by four sessions of RT (ET-RT). The patients in WL were also followed for an additional four weeks. The three research conditions, RT-ET, ET-RT and WL, were compared with respect to change on remoralization and symptom reduction (pre- and post-treatment which was after session 8). We expected to reveal better outcomes for treatment in line with the sequence proposed by the phase model. That is, RT-ET was expected to produce better treatment outcomes than ET-RT because RT-ET is in line with the sequence of change proposed by the phase model. Patients should first receive treatment aimed at remoralization as this provides hope and perspective, which are needed for treatment aimed at the specific symptoms of a disorder (i.e., symptoms of PDA in the present case). ET-RT was expected to be less efficacious because, in the phase model, addressing symptoms immediately does not leave room for attention on remoralization, which is assumed to be needed for effective treatment to start with.

A total of 72 patients with PDA completed the study described in Chapter 5. Compared to WL, significant improvement on remoralization was found for *both* RT-ET (*ES* = 0.52 – 0.88) and ET-RT (*ES* = 0.43 – 0.61). Compared to WL, significant symptom reduction was similarly found for both RT-ET (*ES* = 0.65) and for ET-RT (*ES* = 0.87). Proof for RT-ET being more effective than ET-RT could not be found, thus, for either measure of remoralization or symptom reduction. Treatment that immediately addressed the patient's symptoms and then addressed remoralization was just as effective as treatment that first devoted attention to the patient's state of hopelessness and thereby provided hope and perspective prior to addressing the patient's specific symptoms. In the present study, treatment that was designed in line with the phase model was not found to be more effective than treatment that deviated from the phase model.

Summary of the main findings of the empirical studies

1. Remoralization is appropriately measured by the newly developed RS. This 12-item self-rating instrument is psychometrically sound, easy to administer, and easy to interpret when used in psychotherapy outcome research with mental health care patients.

2. Remoralization is sensitive to therapeutic change in patients suffering from PDA. This is the case for all studied treatments (panic control treatment, medication treatment using SSRI, RT, ET, RT-ET, and RT-ET).
3. Remoralization and symptom reduction follow the same change pattern over time.
4. Remoralization is associated with beneficial changes in health related QoL while symptom reduction is not.
5. Treatment effects for remoralization and symptom reduction cannot be distinguished from each other: Treatment strictly focused on only one of the measures (i.e., either remoralization or symptom reduction) proved effective for both measures.
6. A treatment programmed in line with the phase model of Howard et al. (1993) is no more effective than a treatment that deviates from the phase model. Both treatments effectively produce both remoralization and symptom reduction.

General limitations and considerations

In this section, general limitations and considerations with regard to the reported studies are presented. The information provided is in addition to the discussions in each of the previous chapters and thus of a more general nature.

In all of the treatment studies (Chapter 2: study 5, Chapters 3, 4, and 5), the patient samples were rather small. Replication with larger sample sizes is therefore required. The experimental study in Chapter 5, in which the effects of two treatments (i.e. RT-ET and ET-RT) — that turned out to be both effective — were directly compared, certainly requires replication with a larger sample because proof of non-existence of different effects between two effective treatments requires a larger sample than we had. However, we have no indication that a larger patient sample would yield completely different results; there is strong evidence, that the implication of the phase model, that a treatment needs first to be focused on a patients' remoralization, does not hold.

For the development of the RS, different patient samples were used. In the treatment studies, however, only patients with PDA were included. The present findings therefore cannot, strictly speaking, be generalized to other groups of patients. The reason for concentrating on this specific group of patients in the treatment studies was methodological. In previous studies that tested the phase model (Callahan et al., 2006; Hilsenroth et al., 2001; Holloway, 2004; Howard et al., 1993; Joyce et al., 2002; Kopta et al., 1994; Lutz et al., 2001; Martinovich, 1998), *general* symptom checklists were administered to measure the level of symptoms. These instruments are known to measure mostly general distress while distress is considered an important part of the

state of being demoralized (de Figueiredo & Frank, 1982). General symptom checklists are thus not suited to distinguish remoralization from symptom reduction. It was therefore decided in our project to include a patient group that has been not only well-researched and well-described in the literature but also has well-documented and suitable measurement instruments available to assess its specific symptoms. This was the case for patients with PDA. This group was also attractive because a specific, empirically supported treatment was available for patients with PDA as well. According to the literature, the group of patients with PDA is, moreover, one of best responding to psychological treatments (Oei, Llamas, & Devilly, 1999; van Balkom, et al., 1997). We have no particular reason to believe that the present results would not hold for other patient groups — that is, patient groups that are known to respond well to empirically supported treatment and for which specific symptom measurement instruments are available. Future studies should, of course, nevertheless be conducted to document this.

However, it is not inconceivable that different change patterns for remoralization and symptom reduction can be detected for highly different groups of patients. For patient populations with such chronic conditions as schizophrenia or somatization disorder, different change patterns can perhaps be expected because symptom reduction is much less likely to occur than remoralization in such cases (Shrivastava, Johnston, M., Shah, & Bureau, 2010; Strauss, 1994). Further study of remoralization in chronic patient samples is thus necessary to attain a full understanding of remoralization.

One might raise objections to the fact that the sample reported on in Study 5 of Chapter 2, was the same sample as in Chapter 3. We belief, however, that this causes no problems since the aim of the studies was very different and in Study 5 of Chapter 2 only pre and post assessments were used. In addition to the other studies of Chapter 2 on the development, reliability and validity of the RS, the goal of this study was only to globally determine the RS' sensitivity to change. In Chapter 3, on the other hand, all eight measure points were used to compare patterns of change across various points in time between remoralization and symptom reduction.

Given that the purpose of the studies in Chapters 4 and 5 was to elaborate upon the phase model, the SWS of Howard et al. was also included as a measure of remoralization. In fact, the SWS was used as the primary measure of remoralization and the RS as a secondary measure due to missing RS data. The results of both studies showed the SWS and RS scores to be comparable. For the research questions posed in Chapters 4 and 5 the detected small differences were not of interest. In retrospect, however, these findings raise the question of whether the SWS and the RS are equally well-suited to study the course of remoralization during psychotherapy. We could not know a priori that the SWS would turn out to be quite appropriate in these studies. Knowing what we do now, however, we still consider the RS a better alternative for the measurement of remoralization than the SWS. First, the RS has been clearly tested and documented in the five studies presented in Chapter 2 using several samples that include

a wide variety of mental health care patients and also non-patients. Second, the RS is large enough to have good reliability and validity but small enough to be easily administered on repeated occasions for purposes of outcome research. The SWS, in contrast, is very brief with only three items in the version used here; this means that the reliability and content validity of the scale can easily drop below acceptable values, which is not the case for the RS. Third, various versions of the SWS have been used. This means that an agreed-upon version of the SWS does not exist, and it is not clear which version should be preferred (i.e., the two-item version of Howard et al., 1993; the three-item version of Grissom, Lyons, & Lutz, 2002; the four-item version of Callahan et al., 2006). Fourth, according to de Figueiredo and Frank (1982), demoralization involves two dimensions: subjective incompetence and distress. However, all three versions of the SWS lack items to assess subjective incompetence, which means that the SWS does not encompass Frank's broader definition of demoralization. The RS, in contrast, does.

In the experimental studies presented in Chapters 4 and 5, we followed patients undergoing treatment across a relatively short period of time (i.e., four and eight sessions). On the basis of the phase model, it was expected that remoralization and symptom reduction would be distinguishable within this period of time (i.e., in response to the first few sessions of treatment). It is, nevertheless, theoretically possible that remoralization and symptom reduction only become distinguishable later on in treatment. The results of the naturalistic study presented in Chapter 3, on the other hand, show this to be unlikely as the change patterns for remoralization and symptom reduction correlated highly across the longer period of 28 weeks as well. It is not likely that we have missed the opportunity to clearly separate remoralization from symptom reduction due to the short treatments in our experimental studies.

Implications of the findings

In discussing the implications of the results of the research reported here for the phase model and the main research question of this dissertation, the limitations and considerations pointed out above should be taken into account. The implications for the phase model of Howard and colleagues (1993) will first be discussed. Thereafter, the implications for the main research question will be discussed.

The phase model was judged to be attractive and theoretically valuable for clinicians given its simplicity, transparency, and detailed description of the phases of psychotherapy change. Clinicians report recognition of the phases of change for all kinds of patients from clinical practice (Joyce et al., 2002). As described in Chapters 4 and 5, however, empirical tests of the phase model in the past (Barkham et al., 1996; Callahan et al., 2006; Hilsenroth et al., 2001; Holloway, 2004; Howard et al., 1993;

Joyce et al., 2002; Kopta et al., 1994; Lutz et al., 2001; Martinovich, 1998) suffer from a number of methodological drawbacks, and the results are ambiguous at best, and thereby hinder confirmation or disconfirmation of the basic assumptions underlying the phase model. According to the phase model, the first phase of change is remoralization and the second phase is symptom reduction. In the studies described in Chapters 3 and 4, however, remoralization could not be distinguished from symptom reduction. Instead, both co-occur. This co-occurrence of remoralization and symptom reduction may additionally explain the absence of confirmation for the assumptions underlying the phase model by the previous studies. That is, it is not possible to show that change in the first phase of treatment precedes change in the second phase or that change in the first phase is necessary for change in the second phase to occur as the effects for remoralization (i.e., phase one) and symptom reduction (i.e., phase two) are indistinguishable. In combination with the fact that we could not find evidence in Chapter 5 that a treatment sequence that was in line with the phase model (i.e., RT followed by ET) was more effective than a treatment sequence that deviated from the model (i.e., ET followed by RT), these findings seriously question the appropriateness of the outline of psychotherapeutic change that is provided by the phase model.

The main research question in this dissertation was: Is remoralization a valuable outcome measure supplementary to the measurement of symptom reduction in psychotherapy outcome research? There are several answers to offer. We start with several practical issues and then, finally, theoretically address the relation between symptom reduction and remoralization.

The research of this dissertation resulted in a proper and useful instrument to measure remoralization. As expected, remoralization was found to be a concept that is sensitive to psychological changes and suitable for repeated assessment during the course of treatment. The present research has thus contributed to our knowledge of remoralization as it has shown the measurement of remoralization to be clearly possible and bona fide treatments to produce satisfactory increases in remoralization compared to a waiting list. This is in line with expectations derived from the theory of Jerome Frank in which it is stated that remoralization is a crucial aspect of effective treatment (see, for instance, Frank & Frank, 1991). The inclusion of remoralization as an outcome measure in psychotherapy outcome research thus appears to be valuable and meaningful.

The inclusion of remoralization is also likely to broaden the perspective on outcome measures in psychotherapy research and, by doing so, it might contribute to the improvement of the overall acceptance of research outcome as the criticism that the research only reflects the amount of symptom reduction will no longer hold. Positive consequences for the implementation of research findings into actual clinical practice may also be a result. In light of the broader perspective taken on treatment outcome, therapists may feel that their practices are better reflected in research results.

From the perspective of patients, the addition of remoralization to psychotherapy outcome measurement may also provide a more complete picture as only a small minority of patients mentioned symptom reduction as the only or most important goal of treatment (Grosse Holtforth & Grawe, 2002). For those patients groups that are known to be difficult to cure from the perspective of symptom reduction and thus designated as *untreatable* in the current research paradigm, the measurement of remoralization may result in the idea that these patients groups are treatable.

Now that we know that the measurement of remoralization is perfectly possible and that bona fide treatments can increase remoralization, we can now consider the relation between remoralization and symptom reduction. The present results show the two measures to be difficult to distinguish. Scores on the measures co-occurred and co-varied in the present studies. This co-variance could be caused by the (methodological) decisions we have made such as the patient samples we studied or the duration of the treatments (see Limitations and considerations), but in the series of studies conducted here, we were not able to unravel the two. Akin to lightning and thunder, which co-occur but are clearly different phenomena, remoralization and symptom reduction might then co-occur but are distinct psychological processes with very different content and significance. The only result that points in the direction of a distinction between remoralization and symptom reduction in the present research is that described in Chapter 3 where remoralization and symptom reduction clearly overlapped but only remoralization related to health-related QoL. The general functioning of the patient at work or during daily activities and experienced mental health correlated with remoralization but not with symptom reduction.

Overall and until replication possibly proves otherwise, it is most straightforward to conclude that remoralization and symptom reduction cannot be distinguished from each other in psychotherapy outcome research. Remoralization does not appear to occur without symptom reduction and, conversely, symptom reduction does not take place without remoralization. A new perspective and regained hope appear to ease the negative impact of the symptoms of a mental disorder to at least a certain extent; conversely, reduced fear, less avoidance, and fewer panic attacks foster a more realistic perspective on the part of a patient and thereby hope.

Given that remoralization and symptom reduction have proved indistinguishable during the course of treatment in the studies of this dissertation, the question that should now be asked is what the value of remoralization measurement is, supplementary to symptom reduction measurement. Apparently, when symptom reduction is assessed in outcome research, change on remoralization can be predicted, as well. This suggests that remoralization need not be assessed in addition to symptom reduction. On the other hand, this line of reasoning permits the alternative conclusion as well: the measurement of remoralization makes the measurement of symptom reduction redundant. That is, the demonstration of remoralization is sufficient to indicate the effectiveness of a treatment

as symptom reduction measurement adds nothing to remoralization measurement — at least for a group of patients with PDA.

The question can next be raised whether we would have been able to really measure a distinction between remoralization and symptom reduction on the basis of our measurements. In all of the studies reported on here, self-report instruments were used to measure both remoralization and symptom reduction. Patients rate their own level of remoralization and their own level of symptoms on the basis of their subjective perceptions. For the measurement of remoralization, there is no doubt that this method is most suitable. Remoralization is all about the person's subjective perceptions, sense of self-worth, and perceived ability to meet goals. However, for the measurement of symptoms, the suitability of self-report instruments is open to debate. Actually, one can wonder whether patients are capable of carefully estimating the extent to which they suffer from a range of symptoms typical of a disorder. Further investigation of the relationship between remoralization and symptom reduction using alternative forms of symptom measurement, such as observer ratings, behavioral approach tests, or so-called implicit measures of symptoms, might very well show self-reports of symptomatology — which is by far the most frequently used measurement method in psychotherapy outcome research today — to produce less straightforward and clearly interpretable research results than is often assumed.

Elaborating on the above, it is the question whether it really makes sense to try to distinguish between *actual* (i.e. identifiable, and countable) symptoms and the *experience* of being bothered and hampered by having symptoms, as being two separate notions. Such a distinction between factual symptoms and the experience of symptoms is in line with the medical model adopted in the current psychotherapy outcome research paradigm. Whether or not this distinction holds or is helpful for most mental disorders is very much the question. For a mental disorder such as a panic disorder, the assumption that actual symptoms can be separated from experienced constraints seems rather artificial. In stead, it seems obvious that many psychological problems are about recurrent unwanted feelings and thoughts, and that symptoms of the disorder *are* exactly what the patient experiences. Perhaps we were unable to distinguish remoralization from symptom reduction in this dissertation, precisely because, just as symptoms, remoralization *is* what the patient experiences.

Chapter 7. Samenvatting en Algemene Discussie

Het meten van remoralisatie: een verbreding van hedendaags onderzoek naar de effecten van psychotherapie

Achtergrond

Het hedendaags onderzoek naar de effecten van psychotherapie bij patiënten in de geestelijke gezondheidszorg (GGZ) schiet tekort. De huidige onderzoeksgeneratie stelt zich voornamelijk de vraag in hoeverre een specifieke behandeling effectief is ten aanzien van het verminderen van symptomen die kenmerkend zijn voor de behandelde stoornis. Natuurlijk is symptoomreductie van groot belang, maar zoals in hoofdstuk 1 van dit proefschrift is beargumenteerd, lijkt een effectieve behandeling meer te bewerkstelligen dan symptoomreductie alleen. In hedendaags effectonderzoek worden echter nauwelijks andere positieve behandeleffecten onderzocht. In hoeverre patiënten als gevolg van psychotherapie verbeteringen ervaren in hun subjectief welbevinden, in de kwaliteit van hun sociale relaties, in hun gevoel van controle of hoop, is zelden of nooit onderwerp van onderzoek. De eenzijdige focus op symptoomreductie is zo ingeburgerd in het bestaande effectonderzoek, dat een behandeling vaak wordt aangeduid als effectief, zonder vermelding dat 'effectief' hier feitelijk betekent 'effectief met betrekking tot symptoomreductie'.

Als reactie op deze eenzijdige focus op symptoomreductie pleit een toenemend aantal auteurs voor een verbreding van de meting van psychotherapie-effecten. 'Remoralisatie' lijkt een veelbelovende, complementaire uitkomstmaat om effectenmetingen van psychotherapie te verbreden. Naar verwachting zal een goede therapie naast symptoomreductie ook leiden tot remoralisatie. Remoralisatie houdt in: het herwinnen van hoop en perspectief en het hervinden van vertrouwen in de oplosbaarheid van de ervaren problemen. Remoralisatie als positieve uitkomst wordt bovendien erkend in verschillende psychotherapeutische tradities.

Remoralisatie is afgeleid van het begrip demoralisatie. Jerome Frank stelde in 1974 dat mensen die psychotherapeutische hulp zoeken niet alleen lijden aan een specifiek psychisch probleem (symptomatisch lijden), maar zich meestal ook gedemoraliseerd voelen. Demoralisatie beschreef hij als een toestand van isolatie en wanhoop. Het proces waarin deze toestand van demoralisatie wordt opgeheven wordt remoralisatie genoemd. Frank veronderstelde dat een effectieve behandeling zowel remoralisatie als symptoomreductie zou moeten bewerkstelligen. Frank ging er dus impliciet van uit dat remoralisatie en symptoomreductie twee verschillende processen zijn, die los van elkaar kunnen optreden gedurende de behandeling. Ook Howard en collega's beschreven in het bekende *phase model of psychotherapy outcome* (kortweg 'fasemodel'; Howard, Lueger, Malin, & Martonovich, 1993) remoralisatie en symptoomreductie als twee opeenvolgende, dus verschillende, fases van psychotherapeutische behandeling.

Vanuit een theoretisch perspectief zal de toevoeging van remoralisatiemeting een waardevolle bijdrage leveren aan kennis over effecten van psychotherapie. Daarmee wordt immers de beoordeling van de effectiviteit van psychotherapie verbreed. Maar de feitelijke meerwaarde van remoralisatie als uitkomstmaat blijft onduidelijk zolang effectonderzoek naar remoralisatie ontbreekt. Onduidelijk is nog in hoeverre remoralisatie adequaat kan worden gemeten en of metingen hiervan voldoende gevoelig zijn om veranderingen ten gevolge van psychotherapie vast te stellen. We weten niet in welke mate het zinnig is om remoralisatie te meten. Zo is het mogelijk dat het meten van remoralisatie geen toegevoegde waarde heeft naast het meten van symptoomreductie. Ook weten we niet of met het meten van remoralisatie nieuwe inzichten in de effecten van psychotherapie worden verkregen.

De centrale vraag in het onderhavige proefschrift is daarom als volgt: Is remoralisatie in het onderzoek naar de effecten van psychotherapie een waardevolle aanvullende uitkomstmaat naast het meten van symptoomreductie?

Hieronder volgt een samenvatting van de studies die zijn beschreven in de vier empirische hoofdstukken van dit proefschrift. Daarna worden de conclusies, de algemene beperkingen en overwegingen met betrekking tot de resultaten van deze studies besproken. Ten slotte zal een aantal implicaties van de bevindingen worden geschetst.

De empirische studies: hoofdstuk 2, 3, 4 en 5

Hoofdstuk 2

In de literatuur werd geen geschikt instrument aangetroffen voor het meten van remoralisatie. Daarom was het noodzakelijk om een meetinstrument te ontwikkelen ter bepaling van remoralisatie bij patiënten uit de GGZ. Op basis van deze constatering werd vervolgens de Remoralisatieschaal (RS) ontwikkeld en getest op adequate psychometrische eigenschappen. In hoofdstuk 2 werd dit in vijf studies beschreven. In de eerste werden zes instrumenten geselecteerd die concepten meten die volgens de literatuur geassocieerd zijn met remoralisatie: zelf-waardering, persoonlijke empowerment, gevoelens van competentie, optimisme, besef van innerlijke controle en ten slotte hoop. Deze zes instrumenten werden samengevoegd in een enquête bestaande uit 69 items. In totaal hebben 299 ambulante patiënten de enquête volledig ingevuld. Exploratieve factoranalyses werden uitgevoerd en het aantal items werd gereduceerd tot 16. Deze 16 items vormden samen de initiële RS, die bestaat uit een unidimensionale factorstructuur.

In de tweede studie werden de unidimensionaliteit en de schaalinvariantie van de RS getest in een steekproef met 199 ambulante patiënten en 192 zogenaamde ‘niet-patiënten’ (een willekeurige steekproef uit de Nederlandse populatie). De

veronderstelling daarbij was dat de RS bij zowel patiënten als niet-patiënten, hetzelfde construct op dezelfde wijze zou moeten meten. Op de data werd vervolgens een multi-groep confirmatorische factoranalyse uitgevoerd. Om de RS zo kort mogelijk te houden en ervoor te zorgen dat deze zo gemakkelijk mogelijk in te vullen was, werden vier items met lagere factorladingen verwijderd. Dit resulteerde in een lijst van 12 items: de definitieve RS. Een factoranalyse leverde verder bewijs voor zowel de unidimensionaliteit als de schaalinvariantie van de definitieve RS en toonde aan dat zowel patiënten als niet-patiënten de items van de RS op dezelfde wijze begrepen. De RS bleek dus bij patiënten en niet-patiënten hetzelfde concept te meten.

In de derde studie werd de test-hertestbetrouwbaarheid en interne consistentie van de RS getest in een steekproef met 124 studenten. De test-hertestbetrouwbaarheid over een periode van een week bleek goed (r = .89). De interne consistentie van de RS bleek eveneens goed (α = .87). Deze Cronbach's alfa was vergelijkbaar met die van de patiëntensteekproef (α = .91) en de niet-patiëntensteekproef (α = .91) uit de tweede studie. De interne consistentie van de RS is dus hoog en vergelijkbaar in verschillende steekproeven. Voorts heeft het verwijderen van de vier items, zoals beschreven in de tweede studie, slechts een verwaarloosbaar effect gehad op de interne consistentie van de RS (de Cronbach's alfa, voor de initiële 16-item versie was .92).

In de vierde studie stond de validiteit van de RS centraal. Eerst werd aangetoond dat de RS differentieerde tussen patiënten en niet-patiënten (uit de tweede studie), aangezien niet-patiënten significant meer geremoraliseerd waren dan patiënten (effect size [*ES*] = 1.87). De constructvaliditeit van de RS werd vervolgens onderzocht door de correlaties van de RS met andere relevante meetinstrumenten voor patiënten uit de GGZ te bekijken. De scores van de RS bleken hoog en negatief samen te hangen met die van de Demoralization Scale (r = –.72; Kissane, Wein, Love, Lee, Kee, Clarke, 2004) evenals hoog en negatief met symptomen van angst (r = –.52) en depressie (r = –.50) gemeten met de General Health Questionnaire (Goldberd, 1972). De scores van de RS bleken daarnaast gematigd en negatief samen te hangen met somatische symptomen (r = –.36) en sociaal disfunctioneren (r = –.37), eveneens gemeten met de General Health Questionnaire. Op basis van deze bevindingen werd geconcludeerd dat de RS een toereikende constructvaliditeit bezit.

In de vijfde en laatste studie van hoofdstuk 2 werd de gevoeligheid voor therapeutische verandering van de RS onderzocht bij een populatie van 24 patiënten die leden aan paniekstoornis met agorafobie. De patiënten kregen een empirisch onderbouwde behandeling (*empirically supported treatment*) voor hun klachten (paniekmanagement of medicamenteuze behandeling met een selectieve serotonine heropnameremmer) en werden gedurende een periode van zes maanden gevolgd. De patiënten verbeterden significant wat panieksymptomen betreft (*ES* = 1.21) zoals gemeten met de Mobility Inventory Avoidance when Alone (Chambless, Caputo, Jasin,

Gracely, & Williams, 1985), en ook wat remoralisatie betreft (*ES* = 1.51) zoals gemeten met de RS. De RS bleek dus gevoelig voor therapeutische verandering.

Samenvattend laten de vijf studies van hoofdstuk 2 zien dat de RS een zelfrapportageinstrument is met een hoge interne consistentie, een excellente test-hertest betrouwbaarheid, een toereikende constructvaliditeit en een goede discriminatieve validiteit die duidelijk gevoelig is voor therapeutische verandering. Met slechts 12 items en een unidimensionale factorstructuur is de RS kort, gemakkelijk af te nemen en eenvoudig te interpreteren.

Hoofdstuk 3

In de studie die in hoofdstuk 3 is beschreven, werd de toegevoegde waarde van het meten van remoralisatie verder onderzocht. In de literatuur worden remoralisatie en symptoomreductie als twee te onderscheiden processen beschreven (Figueiredo, 2007; Frank, 1974; Howard et al., 1993), maar de relatie tussen remoralisatie en symptoomreductie is nooit eerder direct onderzocht.

In het verleden werden meerdere studies uitgevoerd om de basale aannames te onderzoeken die ten grondslag liggen aan het fasemodel (Barkham, Rees, Stiles, Shapiro, Hardy, & Reynolds, 1996; Callahan, Swift, & Hynan, 2006; Hilsenroth, Ackerman, & Blagys, 2001; Holloway, 2004; Joyce, Ogrodniczuk, Piper, & McCallum, 2002; Kopta, Howard, Lowry, & Beutler, 1994; Lutz, Lowry, Kopta, Einstein, & Howard, 2001; Martinovich, 1998). Eenduidig bewijs voor het optreden van de twee fases werd echter niet eerder geleverd. Remoralisatie bleek vooralsnog niet duidelijk te onderscheiden van symptoomreductie. Het zou echter kunnen dat deze eerdere bevindingen werden veroorzaakt door methodologische tekortkomingen. Deze studies gebruikten namelijk ongespecificeerde patiëntensteekproeven, ongespecificeerde behandelingen of behandelingen die waren gericht op een grote variatie aan problemen en syndromen. Er werden ook algemene symptoominstrumenten gebruikt die bijgevolg niet geschikt waren voor het scheiden van remoralisatie en symptoomreductie. Het was met andere woorden onduidelijk of remoralisatie en symptoomreductie elkaar aanzienlijk overlapten of dat ze inderdaad twee te onderscheiden, zij het enigszins gerelateerde, uitkomstmaten van psychotherapie waren.

In onze pilotstudie kregen 24 ambulante patiënten die leden aan paniekstoornis met agorafobie een geïndiceerde, geprotocolleerde, empirisch onderbouwde behandeling. Deze steekproef was dezelfde als die in de vijfde studie van hoofdstuk 2. Na de voormeting, werd, gedurende 28 weken, iedere vier weken de verandering van symptomen van agorafobische vermijding (Mobility Inventory Avoidance when Alone; Chambless et al., 1985), agorafobische cognities (Agoraphobic Cognitions Questionnaire; Chambless, Caputo, Bright, & Gallager, 1984) en van remoralisatie (RS) gemeten. Daarnaast werden bij de voormeting en tijdens de nameting (bij 28 weken) de

veranderingen gemeten in de gezondheidsgerelateerde kwaliteit van leven (RAND-36; van der Zee & Sanderman, 1994).

Zoals verwacht was de empirisch onderbouwde behandeling effectief met betrekking tot symptoomreductie (agorafobische vermijding *ES* = 1.21 en agorafobische cognities *ES* = 1.19). Het patroon van verandering was lineair. Daarnaast bleek de empirisch onderbouwde behandeling ook effectief met betrekking tot remoralisatie (*ES* = 1.45). Ook hier was sprake van een lineair patroon: bij iedere nieuwe meting in een volgend tijdsinterval waren de patiënten consistent meer geremoraliseerd. Remoralisatie bleek dus gevoelig voor therapeutische verandering, gemeten op diverse momenten tijdens de behandeling. De helling (*slope*) voor agorafobische vermijding, voor agorafobische cognities en voor remoralisatie correleerden sterk in de latente groeimodelanalyses ($r = -.50$ tot $-.55$). Die uitkomst betekende dat er sprake was van vergelijkbare veranderingen gedurende de behandeling, op elk van deze drie instrumenten. Tijdens effectief bewezen behandeling veranderen de symptomen van patiënten lijdend aan paniekstoornis met agorafobie dus op vergelijkbare wijze en in een vergelijkbaar tempo als remoralisatie en visa versa.

Om te bepalen of het meten van remoralisatie een (gedeeltelijk) unieke toegevoegde waarde had ten opzichte van symptoomreductie, werden remoralisatie en symptoomreductie gecorreleerd met de verschillende aspecten van gezondheidgerelateerde kwaliteit van leven. De helling van remoralisatie correleerde met positieve veranderingen op een aantal aspecten hiervan, namelijk algemene gezondheidsbeleving, psychische gezondheid, lichamelijke pijn en rolbeperking als gevolg van emotionele problemen. De helling van symptoomreductie correleerde met geen van de aspecten van gezondheidgerelateerde kwaliteit van leven. Met andere woorden, wanneer patiënten remoralisatie ervaren gedurende de behandeling hebben zij ook meer kans om een betere psychische gezondheid te ervaren, met minder beperkingen in het domein van werk en dagelijkse activiteiten, minder lichamelijke pijn en een betere algemene gezondheid.

De conclusie van de studie die is beschreven in hoofdstuk 3 is dat remoralisatie correleerde met symptoomreductie en eveneens een unieke relatie had met diverse aspecten van gezondheidsgerelateerde kwaliteit van leven. Hoewel in de studie sterk was ingezet op een grote a priori kans op het vinden van verschillende patronen van verandering betreffende remoralisatie en symptoomreductie door het gebruik van een specifieke patiëntenpopulatie, een goed geïndiceerde, empirisch onderbouwde behandeling en specifieke meetinstrumenten voor remoralisatie en symptoomreductie, konden significant verschillende patronen van verandering niet gevonden worden. Deze bevinding komt overeen met de bevindingen van eerdere studies naar het fasemodel (Callahan et al., 2006; Hilsenroth et al., 2001; Holloway, 2004; Howard et al., 1993; Joyce et al., 2002; Kopta et al., 1994; Lutz et al., 2001; Martinovich, 1998). Het is mogelijk dat de aangeboden behandelingen zowel remoralisatie als symptoomreductie

bewerkstelligden. Om de relatie tussen remoralisatie en symptoomreductie daadwerkelijk te ontrafelen is een experimentele studie vereist waarin de effecten van een behandeling die alleen gericht is op remoralisatie worden vergeleken met de effecten van een behandeling die alleen gericht is op symptoomreductie.

Hoofdstuk 4

In hoofdstuk 4 werden de effecten van een behandeling die alleen gericht is op remoralisatie vergeleken met die van een behandeling die alleen gericht is op de vermindering van symptomen van een specifieke stoornis. Twee duidelijk verschillende vormen van behandeling en een experimenteel onderzoeksdesign werden toegepast met als doel de kansen te vergroten om remoralisatie en symptoomreductie van elkaar te onderscheiden. Als remoralisatie en symptoomreductie van elkaar te onderscheiden zijn, zoals Frank (1973) en Howard en collega's in het fasemodel (1993) suggereerden, zou een behandeling specifiek gericht op remoralisatie niet tot duidelijke symptoomreductie moeten leiden. Omgekeerd zou een behandeling specifiek gericht op symptoomreductie niet tot duidelijke remoralisatie moeten leiden.

Achtenzeventig patiënten die leden aan een paniekstoornis met agorafobie werden willekeurig toegewezen aan óf een vier weken durende remoralisatietherapie (RT) met een strikte focus op remoralisatie, óf een vier weken durende exposuretherapie (ET) met een strikte focus op symptoomreductie, óf aan een wachtlijst (WL) van vier weken. Met het gebruik van korte en strak geprotocolleerde behandelingen werd in een naturalistische behandelsetting een onderzoeksdesign verkregen dat overeenkomsten vertoonde met het design van laboratoriumexperimenten. Hiermee werd de methodologische hoogwaardigheid van laboratoriumexperimenten gecombineerd met de ecologische validiteit van een naturalistische studie met een echte behandeling voor echte patiënten. Metingen werden vóór en na behandeling (na de vierde sessie) verricht. Remoralisatie werd gemeten door gebruik te maken van zowel de Subjective Well-being Scale (SWS; Howard et al., 1993) als de RS. Symptomen werden gemeten met de Panic and Agoraphobia Scale (Bandalow, 1995). Vergeleken met de WL werden verbeteringen gevonden ten aanzien van de beoogde effecten van de behandelingen: RT resulteerde in significante remoralisatie (*ES* = 0.70 – 0.74) en ET resulteerde in significante symptoomreductie (*ES* = 0.72). Daarnaast werden er ook verbeteringen gevonden in de niet-beoogde effecten van de behandelingen vergeleken met de WL: RT resulteerde in significante symptoomreductie (*ES* = 0.55) en ET resulteerde in significante remoralisatie (*ES* = 0.47 – 0.76).

Ondanks deze gecontroleerde, experimentele studie die gebruikmaakte van twee sterk verschillende, korte behandelingen met een 100 % correcte behandelintegriteit, waren we nog steeds niet in staat om de relatie tussen remoralisatie en symptoomreductie te ontrafelen. Het lijkt derhalve onwaarschijnlijk, ten minste voor

patiënten die lijden aan paniekstoornis met agorafobie, dat remoralisatie en symptoomreductie empirisch van elkaar kunnen worden onderscheiden. Dit zou kunnen verklaren waarom eerdere studies naar het fasemodel niet in staat waren om de aannames van het fasemodel te bewijzen.

Hoofdstuk 5

Volgens het fasemodel (Howard et al., 1993) verloopt psychotherapie in een stapsgewijs patroon. Elke fase is afhankelijk van de vorige fase en elke fase kent een ander domein van verandering. De eerste fase van dit model is gebaseerd op de demoralisatietheorie van Frank en Frank (1991) en wordt aangeduid als de *remoralisatiefase*. De tweede fase richt zich op de vermindering van symptomen en wordt aangeduid als de *remediatiefase*. In het fasemodel wordt een vaste volgorde van de fases verondersteld, namelijk remoralisatiefase gevolgd door remediatiefase. Daarnaast wordt verondersteld dat duidelijke verbetering gedurende de ene fase een noodzakelijke voorwaarde is voor verbetering in de volgende fase. Dit houdt in dat zonder significante verbetering in remoralisatie onmogelijk een significante verbetering in symptoomreductie kan optreden.

Hoewel meerdere studies de aannames die ten grondslag liggen aan het fasemodel hebben onderzocht, heeft geen van die studies de vraag aan de orde gesteld of een behandeling die ontworpen is overeenkomstig de veronderstellingen van het fasemodel, effectiever is dan een behandeling die afwijkt van deze veronderstellingen. In dit vijfde hoofdstuk wordt een studie beschreven die deze vraag wél aan de orde stelt. De patiënten die zijn beschreven in hoofdstuk 4 werden vier weken langer gevolgd, waarbij dezelfde meetinstrumenten werden gebruikt. Na de vier in hoofdstuk 4 genoemde sessies, kregen de patiënten in de twee behandelcondities (RT en ET) nog vier sessies van de tegenovergestelde behandeling. Hierdoor werden twee behandelcondities verkregen die bestonden uit acht sessies: óf vier RT-sessies gevolgd door vier ET-sessies (RT-ET), óf vier ET-sessies gevolgd door vier RT-sessies (ET-RT). De patiënten in WL werden ook gedurende vier extra weken gevolgd. De effecten van de drie onderzoekscondities, RT-ET, ET-RT en WL werden met elkaar vergeleken ten aanzien van verandering in remoralisatie en symptoomreductie (voormeting en nameting na sessie 8). We verwachtten dat RT-ET tot betere uitkomsten zou leiden dan ET-RT, omdat RT-ET overeenkomt met de volgorde van verandering zoals in het fasemodel wordt verondersteld. Van ET-RT werd verwacht dat deze tot minder goede uitkomsten zou leiden. Het direct aan de orde stellen van de symptomen zou immers geen ruimte laten aan de remoralisatie die nodig is om een effectieve behandeling van symptomen mogelijk te maken.

Tweeënzeventig patiënten met een paniekstoornis met agorafobie voltooiden de studie zoals beschreven in hoofdstuk 5. Vergeleken met de WL werd er significante

verbetering gevonden op remoralisatie bij zowel RT-ET (*ES* = 0.52 – 0.88) als bij ET-RT (*ES* = 0.43 – 0.61). Vergeleken met de WL werd er tevens significante verbetering gevonden in symptoomreductie voor zowel RT-ET (*ES* = 0.65) als voor ET-RT (*ES* = 0.87). Bewijs dat RT-ET effectiever was dan ET-RT kon bij geen van de uitkomstmaten worden vastgesteld. Een behandeling die onmiddellijk startte met de aanpak van de symptomen en daarna overging op remoralisatie bleek dus even effectief als een behandeling die als eerste gericht was op remoralisatie en daarna pas op de aanpak van de symptomen. Concluderend kan gesteld worden dat in de huidige studie een behandeling die ontworpen was overeenkomstig de veronderstellingen van het fasemodel niet effectiever was dan een behandeling die afweek van deze veronderstellingen.

Samenvatting van de centrale bevindingen van de empirische studies

1. Remoralisatie wordt adequaat gemeten met de nieuw ontwikkelde RS. Dit 12-item zelfrapportageinstrument heeft goede psychometrische eigenschappen, is gemakkelijk af te nemen en eenvoudig te interpreteren wanneer het wordt gebruikt in onderzoek naar de effecten van psychotherapie met patiënten uit de GGZ.
2. Remoralisatie is gevoelig voor therapeutische verandering bij patiënten die lijden aan paniekstoornis met agorafobie. Dit is het geval voor alle in onze studies bestudeerde behandelingen (paniekmanagement, medicamenteuze behandeling met SSRI's, RT, ET, RT-ET en ET-RT).
3. Gedurende de bestudeerde behandelingen volgen remoralisatie en symptoomreductie eenzelfde patroon van verandering.
4. Remoralisatie is gerelateerd aan veranderingen in gezondheidsgerelateerde kwaliteit van leven, terwijl dat voor symptoomreductie niet het geval is.
5. Behandeleffecten voor remoralisatie en symptoomreductie zijn niet te onderscheiden van elkaar: behandeling specifiek gericht op slechts één van de effecten (óf remoralisatie óf symptoomreductie) is aantoonbaar effectief op beide.
6. Een behandeling overeenkomstig het fasemodel van Howard en collega's (1993) is niet effectiever dan een behandeling die afwijkt van dat model. Beide behandelingen zijn effectief in het bewerkstelligen van remoralisatie en symptoomreductie.

Algemene beperkingen en overwegingen

Hieronder worden beperkingen en overwegingen met betrekking tot de gerapporteerde studies besproken. De informatie die wordt gegeven moet als aanvulling worden gezien op de discussies zoals die zijn beschreven in de eerdere hoofdstukken en is van meer algemene aard.

In alle behandelstudies (vijfde studie van hoofdstuk 2, hoofdstuk 3, 4 en 5) waren de steekproeven tamelijk klein. Replicatie met grotere aantallen patiënten is daarom nodig. Dit geldt in het bijzonder voor de in hoofdstuk 5 beschreven experimentele studie, waarin de effecten van twee behandelingen (RT-ET en RT-ET, die beiden effectief bleken) direct werden vergeleken. Het vereist een grotere steekproef dan de onze om te bewijzen dat er een verschil in resultaat is tussen twee effectieve behandelingen. Er waren echter binnen onze bevindingen beslist geen aanwijzingen dat een grotere steekproef tot totaal andere resultaten zou hebben geleid. Er is sterk bewijs dat de veronderstelling van het fasemodel, namelijk dat een behandeling eerst gericht moet zijn op iemands remoralisatie, geen stand houdt.

Voor de ontwikkeling van de RS werden verschillende patiëntensteekproeven gebruikt. In onze behandelstudies werden echter alleen patiënten met paniekstoornis met agorafobie geïncludeerd. De resultaten uit die studies kunnen strikt genomen dus niet gegeneraliseerd worden; ze gelden mogelijk niet voor andere patiëntengroepen. De reden waarom we ons in de behandelstudies concentreerden op patiënten met paniekstoornis met agorafobie was een methodologische. In de eerdere studies die het fasemodel testten (Callahan et al., 2006; Hilsenroth et al., 2001; Holloway, 2004; Howard et al., 1993; Joyce et al., 2002; Kopta et al., 1994; Lutz et al., 2001; Martinovich, 1998) werd gebruikgemaakt van algemene symptoominstrumenten. Het is bekend dat deze instrumenten algemeen psychisch lijden (*distress*) meten, terwijl dat juist een belangrijk aspect van de toestand van demoralisatie is (de Figueiredo & Frank, 1982). Algemene symptoominstrumenten zijn daarom ongeschikt om remoralisatie en symptoomreductie van elkaar te onderscheiden. Daarom besloten wij in het huidige onderzoeksproject een patiëntengroep te selecteren die niet alleen goed onderzocht en goed beschreven is in de literatuur, maar waarvoor ook goed gedocumenteerde en passende meetinstrumenten beschikbaar zijn om de specifieke symptomen te meten. Dit was het geval bij patiënten lijdend aan paniekstoornis met agorafobie. Deze patiëntengroep was ook aantrekkelijk omdat daarover specifieke en empirisch onderbouwde behandelingen beschikbaar zijn. We hebben echter geen duidelijke reden om aan te nemen dat de bevindingen uit onze behandelstudies niet zouden gelden voor andere patiëntengroepen voor wie ook empirisch onderbouwde behandelingen en specifieke symptoominstrumenten beschikbaar zijn. Toekomstig onderzoek zal moeten worden uitgevoerd om hier meer duidelijkheid over te verschaffen.

Voor heel andere patiëntengroepen is het echter niet ondenkbaar dat remoralisatie een ander patroon van verandering laat zien dan symptoomreductie. Bij patiëntengroepen met chronische aandoeningen, zoals schizofrenie of somatisatie-stoornis, zou verwacht kunnen worden dat er geen verandering optreedt in symptoom-reductie, terwijl er wel verandering in remoralisatie optreedt (Shrivastava, Johnston, M., Shah, & Bureau, 2010; Strauss, 1994). Verder onderzoek naar remoralisatie bij chronische patiëntengroepen is noodzakelijk om een volledig inzicht in remoralisatie te krijgen.

Men kan bezwaren hebben tegen het feit dat de steekproef waarover werd gerapporteerd in studie 5 van hoofdstuk 2 dezelfde is als in hoofdstuk 3. Wij zijn echter van mening dat dit geen probleem oplevert aangezien de doelstelling van de studies verschillend is en in studie 5 van hoofdstuk 2 alleen de voor- en nametingen zijn gebruikt. Het doel was om, in aanvulling op de andere studies van hoofdstuk 2 naar de ontwikkeling, betrouwbaarheid en validiteit van de RS, globaal de gevoeligheid voor verandering van de RS te meten. In hoofdstuk 3 daarentegen zijn alle acht metingen gebruikt om de patronen van verandering gedurende meerdere meetmomenten van remoralisatie en symptoomreductie te vergelijken.

De studies zoals beschreven in hoofdstuk 4 en 5 bouwden voort op het fasemodel. Daarom werd de SWS van Howard en collega's toegevoegd aan de RS als maat voor remoralisatie. In feite werd de SWS zelfs als primaire en de RS als secundaire remoralisatiemaat gebruikt omdat er gegevens van de RS verloren waren gegaan. De resultaten van beide studies toonden aan dat de SWS-scores en RS-scores vergelijkbaar waren. Achteraf roepen deze bevindingen de vraag op of de SWS en de RS niet even geschikt zijn om de verandering van remoralisatie tijdens psychotherapie te onderzoeken. Van tevoren konden wij niet weten dat de SWS redelijk geschikt zou zijn voor de beantwoording van onze onderzoeksvragen in deze twee studies. Met de wetenschap van nu beschouwen we de RS echter nog steeds als een beter alternatief voor het meten van remoralisatie dan de SWS. Ten eerste is de RS goed onderzocht en gedocumenteerd in de vijf studies die zijn beschreven in hoofdstuk 2, waarbij verschillende steekproeven werden gebruikt die een verscheidenheid aan patiënten uit de GGZ betroffen alsmede niet-patiënten. Ten tweede is de RS met 12 items van voldoende lengte om over een goede betrouwbaarheid en validiteit te beschikken en tegelijkertijd kort genoeg om gemakkelijk te worden afgenomen bij herhaalde metingen in effectonderzoek. De SWS daarentegen is zeer kort met slechts drie items in de versie die hier gebruikt is. Dit betekent dat de betrouwbaarheid en constructvaliditeit gemakkelijk te laag kunnen worden. Ten derde zijn er verschillende versies van de SWS in omloop (de 2-itemversie van Howard et al., 1993; de 3-itemversie van Grissom, Lyons, & Lutz, 2002 en de 4-itemversie van Callahan et al., 2006). Er is dus geen eenduidige versie en het is niet duidelijk of er een voorkeur bestaat voor één van deze versies. Ten vierde bestaat demoralisatie volgens de Figueiredo en Frank (1982) uit

twee dimensies: subjectieve incompetentie en psychisch lijden. De drie versies van de SWS bevatten echter geen items over subjectieve incompetentie, wat impliceert dat de SWS niet de bredere definitie van demoralisatie van Frank omvat, in tegenstelling tot de RS die wél uitgaat van de bredere definitie.

In de experimentele studies die in hoofdstuk 4 en 5 worden besproken volgden we patiënten die gedurende relatief korte tijd een behandeling ondergingen (namelijk vier en acht sessies). Op basis van het fasemodel zouden we mogen verwachten dat remoralisatie en symptoomreductie gedurende deze periode (namelijk als reactie op de eerste paar sessies van de behandeling) van elkaar te onderscheiden zouden zijn. Het is evenwel theoretisch mogelijk dat remoralisatie en symptoomreductie pas later in de behandeling van elkaar te onderscheiden zijn. De resultaten van de naturalistische studie in hoofdstuk 3 laten aan de andere kant zien dat dit onwaarschijnlijk is, aangezien het patroon van verandering ten aanzien van remoralisatie en symptoomreductie ook hoog correleerde gedurende de langere periode van 28 weken. Het lijkt dus onwaarschijnlijk dat wij, als gevolg van de korte duur van de behandelingen in onze experimentele studies, de mogelijkheid om een duidelijk onderscheid te vinden tussen remoralisatie en symptoomreductie hebben gemist.

Implicaties van de bevindingen

Bij de bespreking van de implicaties van de bevindingen van onze studies moeten de beperkingen en overwegingen die hierboven zijn beschreven in aanmerking worden genomen. Allereerst zullen de implicaties voor het fasemodel van Howard en collega's (1993) worden besproken. Daarna komen de implicaties voor de centrale onderzoeksvraag aan bod.

Clinici vinden het fasemodel aantrekkelijk en theoretisch waardevol vanwege zijn eenvoud, transparantie en gedetailleerde beschrijving van de fases voor allerlei soorten patiënten in de klinische praktijk (Joyce et al., 2002). Zoals beschreven in hoofdstuk 4 en 5 hadden de eerdere studies naar het fasemodel (Barkham et al., 1996; Callahan et al., 2006; Hilsenroth et al., 2001; Holloway, 2004; Howard et al., 1993; Joyce et al., 2002; Kopta et al., 1994; Lutz et al., 2001; Martinovich, 1998) te lijden onder een aantal methodologische tekortkomingen en zijn de bevindingen op zijn best ambigu, waardoor bevestiging of weerlegging van de basale assumpties van het model wordt bemoeilijkt. Volgens het fasemodel vormt remoralisatie de eerste fase van verandering en symptoomreductie de tweede. In de studies beschreven in hoofdstuk 3 en 4 kon remoralisatie echter niet worden onderscheiden van symptoomreductie. Beide traden gelijktijdig op. Dit kan een aanvullende verklaring zijn voor het feit dat eerdere studies de assumpties waarop het fasemodel is gebaseerd niet konden bevestigen. Het is namelijk niet mogelijk om aan te tonen dat verandering in de ene fase vooraf gaat aan

verandering in de volgende fase, of dat verandering in de eerdere fase noodzakelijk is om verandering in de volgende fase te laten optreden, indien de effecten voor remoralisatie (fase 1) en symptoomreductie (fase 2) niet van elkaar te onderscheiden zijn. Omdat we bovendien in hoofdstuk 5 niet konden bewijzen dat een behandelvolgorde overeenkomstig het fasemodel (RT gevolgd door ET) effectiever was dan een omgekeerde behandelvolgorde (ET gevolgd door RT), kunnen er dus serieuze vragen gesteld worden over de juistheid van de beschrijving van de psychotherapeutische verandering zoals die wordt geschetst in het fasemodel.

De hoofdvraag van dit proefschrift was: Is remoralisatie in het onderzoek naar de effecten van psychotherapie een waardevolle aanvullende uitkomstmaat naast het meten van symptoomreductie? Er zijn meerdere antwoorden te geven. We beginnen met een aantal praktische kwesties, waarna we ten slotte de relatie tussen remoralisatie en symptoomreductie theoretisch aan de orde stellen.

Het onderzoek van dit proefschrift resulteerde in een geschikt en bruikbaar instrument om remoralisatie te meten. Zoals we verwachtten bleek remoralisatie een concept dat gevoelig is voor psychologische verandering en geschikt voor herhaalde metingen gedurende het verloop van de behandeling. Het huidige onderzoek heeft daarom bijgedragen aan de kennis over remoralisatie. Het onderzoek heeft aangetoond dat de meting ervan goed mogelijk is en dat de geboden behandelingen voldoende verandering bewerkstelligen in relatie tot een wachtlijst. Dit is in overeenstemming met de verwachtingen op basis van de theorie van Jerome Frank waarin wordt verondersteld dat remoralisatie een cruciaal aspect is van een effectieve behandeling (zie bijvoorbeeld Frank & Frank, 1991). Het lijkt daarom waardevol en belangrijk remoralisatie als uitkomstmaat in onderzoek naar de effecten van psychotherapie op te nemen.

Het opnemen van remoralisatie zal vermoedelijk het perspectief op uitkomstmaten in onderzoek naar de effecten van psychotherapie verbreden. Dit zou tot een toename van algehele acceptatie van de resultaten van dergelijk onderzoek kunnen leiden. Kritiek dat dergelijke resultaten alleen maar symptoomreductie betreffen, is dan immers niet langer houdbaar. Opnemen van remoralisatie als uitkomstmaat kan positieve consequenties hebben voor de implementatie van onderzoeksresultaten in de klinische praktijk. Therapeuten zullen waarschijnlijk vinden dat, door het bredere perspectief op behandeleffecten, hun praktijk beter wordt gereflecteerd in de onderzoeksresultaten.

Vanuit het perspectief van patiënten kan het opnemen van remoralisatie als uitkomstmaat ook zorgen voor een completer beeld, omdat slechts een klein deel van de patiënten symptoomreductie als enige of meest belangrijke doel van behandeling noemt (Grosse Holtforth & Grawe, 2002). Voor patiëntengroepen die bekend staan als moeilijk te genezen in termen van symptoomreductie en daardoor het stempel *onbehandelbaar* krijgen in de huidige onderzoeksgeneratie, kan het meten van remoralisatie resulteren in het besef dat zij wel degelijk behandelbaar zijn.

Nu we weten dat het meten van remoralisatie goed mogelijk is en dat betrouwbare behandelingen remoralisatie bewerkstelligen, kunnen we de relatie tussen remoralisatie en symptoomreductie nader bekijken. De huidige resultaten laten zien dat de twee maten moeilijk te onderscheiden zijn. De verandering op beide uitkomstmaten traden samen op en covarieerden in de huidige studies. Deze covariantie zou kunnen worden veroorzaakt door de (methodologische) keuzes die we hebben gemaakt, zoals de patiëntenpopulatie die we onderzochten of de duur van de behandelingen (zie Algemene beperkingen en overwegingen). In de serie van studies die hier werden uitgevoerd waren wij echter niet in staat die relatie te ontrafelen. Zoals bliksem en donder samen optreden, maar ook twee duidelijk te onderscheiden fenomenen zijn, zouden remoralisatie en symptoomreductie ook samen kunnen optreden en toch twee te onderscheiden psychologische processen met verschillende inhoud en betekenis kunnen zijn. Het enige resultaat dat in de richting van onderscheid tussen remoralisatie en symptoomreductie wijst, is beschreven in hoofdstuk 3. Hierin overlapten remoralisatie en symptoomreductie weliswaar sterk, maar was alleen remoralisatie gerelateerd aan gezondheidsgerelateerde kwaliteit van leven. Het algemeen functioneren van de patiënt, op het werk en gedurende zijn dagelijkse activiteiten en de door hem ervaren psychische gezondheid, correleerden wél met remoralisatie, maar niet met symptoomreductie.

Over het geheel genomen, tenzij door replicatie mogelijk het tegendeel wordt bewezen, is de meest voor de hand liggende conclusie dat remoralisatie en symptoomreductie niet van elkaar te onderscheiden uitkomstmaten van psychotherapie zijn. Remoralisatie lijkt niet op te treden zonder symptoomreductie en andersom lijkt symptoomreductie niet op te treden zonder remoralisatie. Dit betekent dat nieuw perspectief en herwonnen hoop de negatieve impact van de symptomen van een psychische stoornis verlichten. Omgekeerd geven verminderde angst, minder vermijdingsgedrag en minder paniekaanvallen, perspectief aan patiënten en daarmee herwonnen hoop.

Nu in het verloop van de studies voor dit proefschrift steeds duidelijker lijkt te zijn geworden dat remoralisatie en symptoomreductie niet van elkaar te onderscheiden zijn, is de vraag die op dit moment gesteld moet worden wat de waarde van het meten van remoralisatie is in aanvulling op het meten van symptoomreductie. Wanneer symptoomreductie wordt gemeten kan blijkbaar ook de verandering in remoralisatie worden voorspeld. Dit suggereert dat wanneer symptoomreductie wordt bepaald, remoralisatie niet bepaald hoeft te worden. Aan de andere kant staat deze wijze van redeneren tevens een andere conclusie toe, namelijk dat het meten van remoralisatie het meten van symptoomreductie overbodig maakt. Het aantonen van remoralisatie is immers voldoende om de effectiviteit van een behandeling te bepalen, aangezien het meten van symptoomreductie niets toevoegt aan het meten van remoralisatie. Dit geldt in elk geval voor de groep patiënten met paniekstoornis en agorafobie.

De vraag dient zich vervolgens aan of we met de gebruikte meetmethoden überhaupt wel in staat zouden zijn geweest om een onderscheid te meten tussen remoralisatie en symptoomreductie. In alle studies die hier zijn beschreven werden zelfrapportageinstrumenten gebruikt om zowel remoralisatie als symptoomreductie te meten. Patiënten waarderen hun eigen niveau van remoralisatie en hun niveau van symptomen op basis van eigen, subjectieve, waarnemingen. Voor het meten van remoralisatie bestaat er geen twijfel over dat deze methode de meest juiste is. Remoralisatie gaat namelijk over iemands subjectieve waarnemingen, gevoel van zelfwaarde en waargenomen vermogen om doelen te bereiken. Echter, voor het meten van symptomen is de juistheid van zelfrapportage discutabel. Men kan zich namelijk afvragen of patiënten wel in staat zijn om een zorgvuldige inschatting te maken van de mate waarin zij lijden aan een scala van symptomen behorende bij een bepaalde stoornis. Er zijn alternatieve vormen van symptoommeting zoals observatie-instrumenten, gedragsmaten of zogenaamde impliciete symptoommaten. Het is zeer goed mogelijk dat nader onderzoek naar de relatie tussen remoralisatie en dergelijke alternatieve symptoommaten uitwijst dat zelfrapportage van symptomatologie — veruit de meest gebruikte meetmethode in hedendaags onderzoek naar de effecten van psychotherapie — tot minder vanzelfsprekende en minder duidelijk te interpreteren onderzoeksresultaten leidt dan meestal wordt aangenomen.

Voortbouwend op het bovenstaande kunnen we stellen dat er blijkbaar een verschil gemaakt wordt tussen *daadwerkelijke* (identificeerbare en meetbare) symptomen en de *beleving* van de beperkingen van symptomen als twee van elkaar te onderscheiden fenomenen. Een dergelijk onderscheid tussen de feitelijke symptomen en de beleving van symptomen is in overeenstemming met het medische model dat is omarmd door de huidige generatie onderzoekers op het gebied van de psychotherapie. Bij een somatische aandoening zou een verhoogde lichaamstemperatuur een voorbeeld zijn van een feitelijk symptoom en koude rillingen de daarbij behorende beleving van het symptoom. In hoeverre dit onderscheid houdbaar of behulpzaam is voor de meeste psychiatrische stoornissen is echter zeer de vraag. Voor een psychiatrische stoornis, zoals paniekstoornis met agorafobie, lijkt de aanname van een onderscheid tussen de feitelijke symptomen en de beleefde klachten kunstmatig. Het is namelijk overduidelijk dat veel psychiatrische problemen juist gaan over ongewenste gevoelens en gedachten en dat de symptomen van de stoornis juist bestaan uit wat de patiënt beleeft. Misschien is dit dus de uiteindelijke reden waarom wij in dit proefschrift niet in staat bleken om remoralisatie en symptoomreductie van elkaar te onderscheiden, omdat namelijk remoralisatie, evenals symptoomreductie, juist datgene *is* wat een patiënt beleeft.

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Appendices.
Remoralization Scale, English and Dutch Version

Remoralization Scale – English Version

Instruction: This questionnaire concerns your self-perceptions. Please indicate the extent to which you agree with the following statements by marking the appropriate box. Indicate how you feel at this point in time. Do not think too long before answering; your initial reaction is usually the best. There are no wrong answers.
If you feel that the answer you would like to give is not one of the options, please choose that statement which is closest to your answer. Mark only one box per question.

1. I am in control of my life.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

2. I am usually confident about the decisions I make.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

3. I feel relaxed.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

4. On the whole, I am satisfied with myself.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

5. I enjoy life.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

6. Right now, I see myself as being pretty successful.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

7. I take a positive attitude toward myself.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

8. At this point in time, I am meeting the goals I set for myself.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

9. I feel that I am a person of worth, at least on an equal plane with others.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

10. I am generally optimistic about the future.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

11. I can think of many ways to reach my current goals.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

12. I have self-confidence.
□ totally disagree □ disagree a lot □ agree a lot □ totally agree

Remoralisatieschaal – Nederlandse Versie

Deze vragenlijst gaat over uw zelfbeleving. Wilt u telkens aangeven in welke mate u het eens bent met de uitspraak, door het hokje van uw keuze aan te kruisen. Geef aan hoe u er op dit moment over denkt. Denk niet te lang na over uw antwoord; uw eerste reactie is meestal de beste. Er bestaan geen foute antwoorden.
Wanneer u de indruk heeft dat uw antwoord niet bij de antwoordcategorieën staat, kies dan het hokje dat uw antwoord het best benadert. Kruis per vraag slechts één hokje aan.

1. Ik heb de regie over mijn leven.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

2. Ik heb meestal vertrouwen in de beslissingen die ik neem.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

3. Ik voel me ontspannen.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

4. Over het geheel genomen ben ik tevreden met mezelf.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

5. Ik heb zin in het leven.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

6. Op dit moment vind ik mezelf redelijk succesvol.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

7. Ik sta positief tegenover mijzelf.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

8. Op het ogenblik lukt het me de dingen te realiseren die ik mezelf tot doel heb gesteld.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

9. In vergelijking met anderen vind ik mijzelf even waardevol.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

10. Ik ben in het algemeen optimistisch over de toekomst.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

11. Ik kan momenteel tal van manieren bedenken om mijn doelen te bereiken.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

12. Ik heb zelfvertrouwen.
□ helemaal mee oneens □ grotendeels mee oneens □ grotendeels mee eens □ helemaal mee eens

Dankwoord

Nu mijn manuscript is voltooid mag ik mijn dankwoord schrijven. Veel mensen zijn direct en indirect bij mijn project betrokken geweest en zij verdienen het hier genoemd te worden. Zonder hen was het onderzoek niet mogelijk geweest, of in ieder geval een stuk zwaarder. Het is fijn dat ik ze hier kan noemen en bedanken. Het wordt dus een lange lijst.

In de eerste plaats wil ik graag alle patiënten die deelnamen aan mijn onderzoek bedanken. Zonder hun inspanningen waren er in dit proefschrift geen uitkomsten te vermelden. Het Ambulatorium ACSW, De Gelderse Roos, Hendriks & Roosenboom en vooral de Angstpoli van GGZ Nijmegen (thans Overwaal) wil ik bedanken voor het werven van de patiënten. Gert-Jan, Mirjam Kampman, Agnes, Esther, Mirjam van Rees, Wilbert, Marcel, Judith, Susan, Rianne, Manou, Bram, Anneke, Nicole en alle anderen: bewonderenswaardig hoe goed jullie steeds voor mij in de gaten hielden of patiënten geschikt waren. Met name tijdens de intakevergaderingen van de Angstpoli merkte ik wat een leuk team jullie vormen.

Nicole (jij maakte je op meerdere terreinen onmisbaar), Ruth, Josh, Anneke, Iris, Lieke, Sanne, Anke, Lieke, Marieke, Spence en Lars: dank jullie wel voor je inspanning en enthousiasme bij het leren en het uitvoeren van de onderzoeksbehandelingen. Paul Rijnders, dank je wel voor het bewerken van het kortdurend behandelmodel tot de hier gebruikte remoralisatietherapie en voor het tot driemaal toe trainen van de nieuwe studenttherapeuten. Hedwig, jou wil ik bedanken voor de supervisies van de remoralisatietherapie. Mirjam en Ger, fijn dat de studenttherapeuten tijdens de supervisies konden profiteren van jullie jarenlange ervaring met exposuretherapie.

Ik heb veel hulp gekregen voor het berekenen van de resultaten en het correct en mooi opschrijven hiervan. Graag noem ik hier Lee Ann Weeks voor het corrigeren van de Engelse teksten, William van der Veld, Rinske de Graaff Stoffers en Theo van der Weegen voor de statistische hulp. Raoul Postel, bedankt voor het mooie ontwerp van de omslag.

Portiers van 'het Spinoza' Cor en Ron, bedankt voor de gezellige entree en de praatjes bij het ophalen van de post. Medewerkers van de sectie klinische psychologie, wat fijn dat jullie mij al die jaren hebben geadopteerd! Het was prettig dat ik zomaar een kamer kreeg en dat jullie me onderdeel van de *sectie* lieten voelen. Hiervoor met name ook dank aan Eni. In al die jaren zijn er natuurlijk veel medewerkers en vooral junioren geweest met wie ik gezellig heb geluncht, zoals met Gero, Laura, Julie, Joyce, Machteld, Leontien, Monique, Cilia, Linda, Floor en Anke. Het is onmogelijk om hier iedereen te noemen, maar toch: allemaal bedankt! Maria en Wies, bedankt voor jullie interesse en gezelligheid.

De maandelijkse vrijdagmiddagen met het Manipel, later NijCARE waren ontzettend inspirerend. Het bespreken van mijn en andermans onderzoek heeft me steeds geprikkeld en scherp gehouden. En wat was het ondertussen ook leuk!

Een woord van dank aan De Gelderse Roos, mijn werkgever vanaf 2006, is hier op zijn plaats. Fysiek zat ik in Nijmegen, maar ik voelde me ook thuis op mijn officiële onderzoeksplek Grip (thans ProCES) in Wolfheze. De promovendi-bijeenkomsten waren voor mij een waardevolle gelegenheid om teksten voor te leggen. Alle promovendi van Grip, dank jullie wel. Giel, Bea en Annet, jullie werden vaak gesommeerd om vooral de promovendi aan het woord te laten. Ik ben blij dat jullie je af en toe niet in konden houden: jullie inbreng was waardevol, ik heb veel van jullie geleerd. Gerrit, Bauke en ik, we hebben alle drie de ZonMW-OOG subsidie binnengehaald en zijn alle drie net klaar met ons promotieonderzoek. Ik vond het leuk om dit traject samen met jullie te bewandelen en zal het contact met jullie missen. Bauke, geen lange gesprekken meer totdat de portier van Soeterbeeck gaat slapen. De 'buitenklas' van het ACSW heeft mij sowieso altijd energie en onderzoekszin gegeven.

Caroline, Hanneke, Ger, Huub, Alphons en Miranda, het was heel fijn om een aantal jaar onderdeel van jullie team uit te maken. Het voelt als thuiskomen nu ik weer bij jullie werk. Het SPON ken ik al van voor de GZ-opleiding en het leek mij altijd al een enthousiaste werkkring. Monic, Jan, Hella en de anderen: leuk dat ik daar nu deel van uit mag maken.

Giel en Ger, wat hebben we véél GGW's gehad. Dat waren zeker geen kabbelende besprekingen. We hebben gestreden en het elkaar niet makkelijk gemaakt (soms vooral jullie mij niet). Maar het was ook leuk, inspirerend, behulpzaam en het meest leerzame van alles wat ik in dit hele traject heb meegemaakt. Jullie hebben ontzettend veel in dit project, en dus in mij, geïnvesteerd. Giel, jouw scherpte en bezieling waren als stuwende kracht essentieel om het onderzoek naar grotere hoogten te brengen. Ger, als ik jouw kennis van (experimentele) behandelstudies, van angststoornissen, jouw nauwlettendheid en geduld bij het redigeren toch niet had gehad… hoe had het dan gemoeten?! Dank je wel Giel en Ger. Ik kan me geen beter begeleidingsduo voorstellen. Jullie vulden elkaar zo mooi aan. Ik vraag me af hoe het straks, zonder onze regelmatige GGW's, zal zijn. Hopelijk zetten we de traditie van af en toe een borrel of dinertje voort. Giel, jij blijft mijn baas en daar ben ik blij om.

Nu richt ik mij tot de mensen die minder direct, maar wel persoonlijk, bij mijn onderzoek betrokken zijn geweest. Els, tante en coach, jij liet me inzien dat niemand anders dan ikzelf het mij oplegde dit promotieonderzoek af te ronden. Dank je wel hiervoor. Jij en Peter, bedankt voor jullie liefdevolle interesse en dat jullie zo gek zijn op Jules!

En dan Nienke. Niemand was méér dan jij op de hoogte van mijn onderzoek(sperikelen), onder andere door de talloze fietsritten naar het werk. Het was fijn om dit met je te delen en ik vind het een heel plezierig idee dat jij straks in de aula achter me staat. En ik weet dat dat niet alleen letterlijk is. Ik wil je hier graag bedanken voor je vriendschap. We zetten dit allemaal voort! Eveline en ook Michiel, ik ben blij

met het feit dat onze vriendschap in de afgelopen jaren steeds hechter is geworden. We delen zoveel ervaringen omdat we in dezelfde levensfase zitten. Wat is het fijn dat we nu ook dezelfde woonplaats delen! Eveline, dat jij ook mijn paranimf bent past helemaal bij deze ontwikkeling. Dank je wel.

Lisabeth en Maartje, we zaten in hetzelfde schuitje: promotieonderzoek en de GZ-opleiding tegelijkertijd. We hebben heerlijk samen lopen klagen en roddelen. Jullie kozen moedig een andere weg voor jullie onderzoek, maar onze vriendschap is gebleven. Samen met die andere oud-gripper Hedwig hebben we onze regelmatige etentjes. Dank jullie wel, alle drie, voor die gezelligheid. Irma en Marieke, vriendinnen vanaf de studietijd, bedankt. Vriendschappen maken alles lichter!

Graag richt ik ook een woord van dank aan mijn schoonfamilie. Jullie hebben je, ieder op zijn of haar eigen wijze, betrokken gevoeld bij mijn onderzoek en werkzaamheden. Dank aan jullie allemaal.

Lieve Irene, ik ben blij dat jij mijn zus bent! Niemand die mij en mijn achtergrond zo goed kent als jij. Samen hebben we plezier en we vinden steun bij elkaar. Ik geniet altijd van jouw aanwezigheid en voel me zo heerlijk thuis bij jou en ook bij mijn lieve zwager Jaron. Dank je wel voor dit alles.

Nu ik alle mensen die me na staan de revue laat passeren zie ik hoeveel warmte en betrokkenheid mij omringt. Papa en Mama, jullie waren de allereerste die mij hiermee omringden en jullie zijn hier nooit mee gestopt. Ik ben jullie zó dankbaar, om dat te uiten schieten woorden te kort. Mama, als het even minder gaat hoef ik jou dat nooit te zeggen. Met jouw voelsprieten heb je het soms al eerder door dan ikzelf. Dank je voor al je steun en liefde. Alex, jij bent als een vader, zo betrokken, lief, en geduldig. Ik prijs mezelf gelukkig dat jij in mijn leven bent gekomen. Papa, jouw interesse en geloof in mijn kunnen zijn voor mij als een rots in de branding. Dank je wel voor jouw liefde en vertrouwen. Elisabeth, jij ook bedankt voor je betrokkenheid. Jullie kregen samen vijf jaar geleden Cara en Macha. Lieve zusjes, jullie zijn schatten en kleine doerakken.

Nu wil ik hier met liefde de twee belangrijkste mannen in mijn leven noemen.

Lieve Jules, jij bent de enige in deze hele rij die niet heeft gezorgd dat het onderzoek mogelijk was of dat het makkelijker was. Maar jij hebt met je heerlijke, zonnige, enthousiaste aard zoveel lichtheid in mijn bestaan gebracht dat ik je daarvoor op deze plek zielsgraag wil bedanken. Jij zorgt voor heel veel kleur!

Lieve Joris, nu jij nog, jij maakte het onderzoek zeker makkelijker, zoals jij zovéél makkelijker maakt in mijn leven. Ik wil je bedanken voor het zijn van mijn huis en mijn thuis, en ook voor ons mooie gezin en voor het plezier wat wij samen steeds weer hebben. Jij bent goud waard!

Over de Auteur

Wiede Vissers werd geboren op 19 augustus 1979 in Eindhoven. Zij behaalde in 1998 haar VWO-diploma, waarna zij de studie psychologie aan de Katholieke Universiteit Nijmegen (thans Radboud Universiteit) begon. Zij koos voor de afstudeerrichting klinische psychologie. Na haar afstuderen in 2002 startte zij met haar promotie-onderzoek naar remoralisatie bij het Academisch Centrum Sociale Wetenschappen (ACSW) van dezelfde universiteit. Daarnaast werkte zij tevens als psycholoog op het Ambulatorium Volwassenen van het ACSW. Eind 2005 verwierf zij de ZonMW OOG-subsidie. Vanaf 2006 was zij als wetenschappelijk medewerker in dienst van GRIP (thans ProCES) van De Gelderse Roos, waar zij verder werkte aan haar promotie-onderzoek, waarvan dit proefschrift het resultaat is. Tegelijkertijd startte zij met de opleiding tot GZ-psycholoog bij het SPON. Voor de praktijkopleiding zette ze eerst twee jaar haar werkzaamheden bij het Ambulatorium voort. Na twee jaar vervolgde ze de praktijkopleiding bij De Gelderse Roos, Veluwe Vallei. In december 2009 behaalde zij haar registratie als GZ-psycholoog. Sinds juli 2010 werkt zij als programma-coördinator eerstelijnspsychologie bij het ACSW. Zij volgt tevens de profielopleiding tot eerstelijnspsycholoog bij het SPON.